DOCUMENT RESUME

ED 409 155 RC 021 108

AUTHOR	Marshall, Catherine A.; Johnson, Mikel
TITLE	The Utilization of the Family as a Resource in American Indian Vocational Rehabilitation Projects (Section 130 Projects). Final Report.
INSTITUTION	Northern Arizona Univ., Flagstaff. American Indian Rehabilitation Research and Training Center.
SPONS AGENCY	National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
PUB DATE	96
NOTE	107p.
CONTRACT	H133B30068
AVAILABLE FROM	American Indian Rehabilitation Research and Training Center, Northern Arizona University, Institute for Human Development, P.O. Box 5630, Flagstaff, AZ 86011 ($9).
PUB TYPE	Reports - Descriptive (141) -- Tests/Questionnaires (160)
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	*American Indians; Community Services; *Disabilities; *Family Involvement; Program Attitudes; *Rehabilitation Programs; *Reservation American Indians; Social Support Groups; Surveys; *Vocational Rehabilitation
IDENTIFIERS	Barriers to Participation; Training Needs; Tribal Management

ABSTRACT

Surveys of tribal program directors and staff examined the extent to which American Indian vocational rehabilitation (VR) (Section-130) projects used the family and other natural support systems to provide comprehensive rehabilitation services to transition age adolescents and adults with disabilities. Responses were received from directors of 18 of 22 Section-130 projects existing in 1994 and from 36 staff members working in 15 tribal VR projects. The director survey found that 40 percent of projects were administered by tribal departments of education, 90 percent of directors encouraged family involvement, projects served an average of 82 clients per year, and the most common disabling condition (40 percent) was alcohol or substance abuse. The median unemployment rate was 49 percent, and employment opportunities were concentrated in service areas. Among staff respondents, 83 percent were American Indian or Alaska Native. A third of the staff had worked in VR for less than 1 year, and none was a certified rehabilitation counselor. Direct services staff saw an average of 36 clients. The top three family-related services reported were transportation services, home visitation, and information about the disabling condition. Barriers to family involvement included lack of transportation, lack of knowledge about the VR process, and lack of time. Directors were much more likely than staff to support statements about institutional capacity for family involvement. Identified needs included increased funding, more outreach staff, greater space allotment in facilities, and staff and family training. Contains 21 references. Appendices include survey instruments. (SV)

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THE UTILIZATION OF THE FAMILY AS A RESOURCE IN AMERICAN INDIAN VOCATIONAL REHABILITATION PROJECTS (SECTION 130 PROJECTS)

Final Report

1996

Principal Investigator: Catherine A. Marshall, Ph.D., CRC

Co-Investigator: Mikel Johnson, M.S., CRC

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Institute for Human Development
University Affiliated Program
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American Indian Rehabilitation Research and Training Center

Institute for Human Development
University Affiliated Program
PO Box 5630
Flagstaff, Arizona 86011
(520) 523-4791

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ACKNOWLEDGMENTS

Community-based research can not occur without the support and participation of community members. The community of this research was a very small group of tribally-controlled vocational rehabilitation projects (Section 130) dedicated to serving American Indians with disabilities. While the research was conducted as a mailed survey, and not "in the community," the same processes of participation and mutual respect associated with research conducted in a geographic community were applied. Members of the Section 130 community who assisted in the research process are listed below as members of the Project Advisory Committee.

Project Advisory Committee

Llewellyn (Rusty) Cantrell
Project Director
Assiniboine Sioux Vocational Rehabilitation
Poplar, Montana

Sidney Claymore
Project Director
Vocational Rehabilitation
Standing Rock Sioux Tribe
Fort Yates, North Dakota

Maria Estes
Project Director
Vocational Rehabilitation Program
Lower Brule Sioux Tribe
Lower Brule, South Dakota

Tootsie Gloyne
Project Director
Vocational Opportunities of Cherokee
Cherokee, North Carolina

Randy Hammons
Project Director
Choctaw Nation of Oklahoma
Hugo, Oklahoma

Mike Hermanson
Project Director
The Confederated Salish & Koonetai
Tribes of the Flathead Nation
Pablo, Montana

Stanley Holder
Project Director
Apache Tribe of Oklahoma
Anadarko, Oklahoma

Joe Kelley
Project Director
Kodiak Area Native Association
Kodiak, Alaska

Ray Kent
Director
Bristol Bay Native Association Human Services
Dillingham, Alaska

Mary Meruvia
Project Director
Choctaw Vocational Rehabilitation Program
Mississippi Band of Choctaw Indians
Philadelphia, Missouri

Treva Roanhorse
Director
Navajo Nation Office of Special Education and
Rehabilitation Services
Window Rock, Arizona

Donna Thomas
Project Director
Turtle Mountain Band of Chippewa Indians
Belcourt, North Dakota

SUMMARY

Over the past decade, the rehabilitation literature has consistently called for rehabilitation counselors to utilize the family as a resource to enhance the possibility of successful rehabilitation outcomes for people with disabilities. The purpose of this research was to identify the extent to which American Indian vocational rehabilitation (Section 130) projects: (a) provided services to family members when necessary to ensure successful vocational rehabilitation outcomes, and (b) utilized the family, as well as other natural support systems, to provide comprehensive rehabilitation services to transition age adolescents and adults with disabilities. It was anticipated that the results of this study would give tribal vocational rehabilitation programs a better understanding of the extent to which they are utilizing families to achieve rehabilitation goals. It was further anticipated that these findings would have implications as well for counselors who work with American Indians in off-reservation settings in terms of providing a culturally-sensitive family rehabilitation model of rehabilitation service delivery.

Of the 22 Section 130 projects existent in 1994, the directors of 18 (82%) agreed to participate in the research. Of those directors who agreed to participate, 10 (56%) completed a *director survey* instrument designed to elicit information regarding general information in terms of both program and client characteristics. In addition, 36 Section 130 project staff, including 11 directors, completed a *staff survey* instrument designed to elicit more specific information regarding services and supports provided to families. A total of 15 tribal VR projects are represented in the research results.

Based on information obtained through the *director survey*, the plurality, or most [40% (4)] of the projects were administered through tribal departments of education, and served communities of up to 10,000 residents

[50% (5)]. The majority [90% (9)] of directors *strongly agreed* or *agreed* that they encouraged staff to involve the family in all aspects of the rehabilitation process. On average, the projects each had served 82 clients in the past year, with the plurality [40% (4)] citing alcohol/substance abuse as the most common disabling condition among their clients. Responding directors reported a wide range of unemployment in the communities they served, from 6% to 90%, with a median unemployment rate of 49%. Employment opportunities were reported to be concentrated in services areas such as health care and tourism.

Of those persons responding to the *staff survey*, the majority [83% (30)] were American Indian or Alaska Native, with 17% (6) being Caucasian, not of Hispanic Origin. Staff were equally divided between males and females. Staff reported an average age of 38. The plurality [42% (15)] had held their position less than one year; the plurality [31% (11)] had also worked in the rehabilitation profession for less than one year. A large majority [83% (30)] had worked in the rehabilitation profession for five years or less. Three (27%) of the responding directors were certified rehabilitation counselors (CRC); none of the responding staff were CRCs.

On average, direct services staff reported being assigned 36 clients, and reported dealing primarily with persons having, for example, alcohol or substance abuse disorders, learning disabilities, and diabetes. The top three services in which direct services staff reported involving families included: transportation services, home visitation, and information about the disabling condition. Less frequently provided services included: advocacy for family members, family counseling, multiple-family support groups, and respite care services.

Statistically significant differences were found between the mean responses of directors and the mean responses of direct services staff in regard to institutional capacity for family involvement. For example, directors agreed more strongly than direct services staff that "family needs and issues are frequently discussed during case staffing sessions," "my schedule allows me to visit families in their homes to assess their needs," and "my schedule allows me to work with families in various aspects of the rehabilitation process."

The top three barriers to family involvement as identified by direct services staff included: lack of family transportation, lack of family knowledge about the VR process, and lack of time. Responses to open-ended questions supported these data but suggested that barriers could be overcome with more funding, more education for both family and service providers, more facilities, and more support staff.

Increased funding to support outreach and family needs was cited as the *largest need to implement a new system that focused on family* members as well as the individual being rehabilitated. Also identified were needs such as more staff to do outreach and to provide supportive services such as transportation. Finally, facilities with greater space allotment for meeting with families, and training for both families and rehabilitation staff would be necessary. Families would be trained in what is available through VR and staff would be made aware of the services that a counselor can provide to family members.

The Utilization of the Family as a Resource in American Indian Vocational Rehabilitation Projects (Section 130 Projects)

In a recent qualitative study of the needs and support systems of American Indians with disabilities (Marshall, & Cerveny, 1994), it was found that family members had no idea that, in addition to their relative who had a disability, they also could be served by vocational rehabilitation. Further, the family members demonstrated minimal understanding of the range of services available to their relative with a disability. The study, conducted through the American Indian Rehabilitation Research and Training Center (AIRRTC) at Northern Arizona University, involved face-to-face, open-ended, in-depth interviews with 10 American Indian families living on the Eastern Band of Cherokee Indians reservation (served at the time of the research by the North Carolina Department of Human Resources, Division of Vocational Rehabilitation), and 10 families living on the Mississippi Band of Choctaw Indians reservation (served by Choctaw Vocational Rehabilitation, a Section 130 project).

Over the past decade, the rehabilitation literature has consistently called for rehabilitation counselors to utilize the family as a resource to enhance the possibility of successful rehabilitation outcomes for persons with disabilities (e.g., Power & Dell Orto, 1980; Sutton, 1985). Federal regulations for vocational rehabilitation services have confirmed that "services to members of an individual with handicap's family when necessary to the vocational rehabilitation of the individual with handicaps" can be provided by the rehabilitation counselor [34 CFR Ch. III (7-1-90 Edition, p. 287)].

A consensus statement regarding research on people with disabilities *and their families*, derived from participants attending a conference sponsored by the National Institute on Disability and Rehabilitation Research (NIDRR) and coordinated by the University of Kansas, Beach Center on Families and Disability, included the position that the goals of research should be to "expand choices" and "build on strengths" (Turnbull & Turnbull, 1989, p. 1). Most recently, Leung (1993) has pointed out the need to involve family members in the rehabilitation process, and suggested that with the changing demography of the United States as documented by the 1990 U.S. Census, new models of vocational rehabilitation service delivery may need to be developed. He noted that "the present system was developed to meet the needs of veterans who became disabled . . ., [and] is predicated on a one-to-one relationship" between the rehabilitation counselor and the client (p. 9). Leung observed that "with changes in clientele, different models may need to be explored . . ., [and that] recognition not only of the roles of family member, but also their importance in issues such as the motivation for rehabilitation, may be important in such a family rehabilitation model" (p. 9).

Given the importance of the family among American Indian cultures, a better understanding of the extent to which American Indian vocational rehabilitation (VR) projects (Section 130 projects) utilize the family as a rehabilitation resource is needed. The findings from such research could form the foundation of a family-focused rehabilitation model of service delivery. A family-focused rehabilitation model would be of benefit to Section 130 clients and their families, as well as the public VR system, as it strives to meet the needs of its diverse citizenry.

The purpose of this research was to identify the extent to which American Indian VR Projects: (1) *provide services to family members when necessary* to ensure successful vocational rehabilitation outcomes, and (2) *utilize the family*, as well as other natural support systems, to provide comprehensive rehabilitation services to transition age adolescents and adults with disabilities.

Research Questions

1. To what extent are families utilized by tribal vocational rehabilitation projects in the rehabilitation of American Indians with disabilities? What barriers exist which prevent families from being more fully utilized?

2. What procedures do tribal vocational rehabilitation counselors and staff typically employ when working with families?

3. To what extent are the family members provided with services, what are the services which are provided, and how are these services documented?

4. What training needs do tribal vocational rehabilitation counselors and staff have as regards working with families?

5. What recommendations can tribal vocational rehabilitation counselors and staff make as regards necessary components of a family rehabilitation model of service delivery (versus the traditional client-centered model)?

REVIEW OF THE LITERATURE

While the past decade of published research and commentary regarding the role of the family in rehabilitation has advocated for more understanding of family needs, and for professionals to view the

contributions of family members more favorably, it would appear that such recommendations have had little impact as regards actually changing the focus of client-oriented service delivery systems. In a recent annotated bibliography containing abstracts of 251 articles on this topic, McManus and Friesen (undated) noted that "there has been much more study of parents' characteristics and needs than of either the nature of the parent-professional relationship or the characteristics of effective programs involving or responding to the needs of parents" (p. 2). One publication which does document the characteristics of effective programs, and gives examples of existent programs, is entitled *Family-Centered Care for Children with Special Health Care Needs;* its authors noted that "during the last thirty years, systems of care for children with chronic illnesses and disabling conditions have evolved that have not recognized adequately the support needs of families whose children have special health care needs or the essential roles that parents play in the lives of their children" (Shelton, Jeppson, & Johnson, 1987, p. 1). These authors reported that in "family-centered care," "family decisions are the primary consideration in how services are planned and provided. These plans are based on the strengths as well as the needs of the family. . . . Though professional recommendations are critical to the service plan, the parents greatly influence how, when, and where these services are provided" (p. 5).

Many vocational rehabilitation professionals would be quick to point out that "family-centered" programs most often deal with children, whereas they deal with adults who may not need or want their families involved in the rehabilitation process. Again, the point can be made that just as often, many clients may not know that they have the choice to have their families involved, or understand the extent to which their family members could be

served. Cottone and Cottone (1992) have confirmed that "the family has been largely ignored by current rehabilitation programs in both the state-federal and insurance rehabilitation systems, even though the family has been recently legally recognized in rehabilitation statutes" (p. 22). They suggested that rehabilitation counselors must systematically "view the client not as an isolated individual with a disability, but as a potential relational link in a complex relationship network," and concluded that "the best example of a system of significance to the work-relevant role, and the most important system worthy of analysis in rehabilitation, is the client's family system" (p. 22). Similarly, English (1990) has stated that based on his research, "family support, both instrumental and social/interpersonal, appears to be the key ingredient to success in transition from school to work" (p. 11).

Barriers to working with family members may well include overwhelming caseload sizes, budget limitations in terms of actual service delivery, and lack of training in counseling with families or small groups. However, according to Emener (1991), a leading rehabilitation counselor educator, "it would appear very appropriate and helpful for rehabilitation counselors to occasionally ask themselves, 'Is it possible that one of my client's family members could be more helpful to my client than I could be? And if this is the case, how can I facilitate the family member's providing such helpful assistance?'" (p. 9). Emener (1991) "suggested that rehabilitation counselors work with families and assist them [as a unit] in establishing and maintaining economic security" (p. 9).

The Rehabilitation Act Amendments of 1992 (P.L. 102-569) clearly stated that the policy of the United States public vocational rehabilitation system calls for services to be provided "in a manner consistent" with the principle that "families and natural supports can play an important role in

the success of a vocational rehabilitation program, if the individual with a disability requests, desires, or needs such supports" (p. 106 STAT. 4366). As Emener stated, it is the responsibility of the rehabilitation professional to assess the need for family involvement as part of a client's overall evaluation and service needs planning.

It can not be denied that people with disabilities are often integrally involved in larger social units, that is, their families, and play a variety of different roles within those families. In the study referred to earlier regarding American Indian families, often as not, the adult family member who had a disability maintained a role as "caregiver" (Marshall & Cerveny, 1994). For example, researchers were introduced to a mother with paraplegia who had two teenage daughters; interviewed the family of a young mother (age 21) with severe brain injury since infancy, who had a child (age 3); and interviewed a father with paraplegia who had three young daughters. Individual needs ranged from "None, I'm doing fine--I'm a mentor here to other people in chairs," to feelings of despair that the tribal housing authority would never modify the family's reservation home so that the father could check on his daughters in their bedrooms.

Family members expressed feelings of isolation, as well as the need for support and contact with others in a similar situation. For example, one Cherokee elder, whose son had mental retardation and demonstrated signs of mental illness, stated at a focus group meeting (Marshall & Cerveny, 1994):

> *I find that, there's a need there--visitation. . . . I think we're in, I guess were in a fast-moving world, it's a fast-moving business. If you wanna put it in a business way, because it's always business that comes before visitation, and so, I think that has a lot to do with all of us visiting. We don't have time to visit with anyone, anyone. You know, we don't*

> *take that time. If we have the time, you know, we have other things to do--we never think of visitation* (p. 109).

For these families, support was necessary for maintaining a marital relationship, caring for children, accomplishing household tasks, and providing for the economic well-being and security of the family (Marshall & Cerveny, 1994). Cottone and Cottone (1992) suggested that the following services may be necessary to serve families involved in rehabilitation where an adult family member has a disability: child care, child support, flexible educational programming and work settings, transportation assistance to multiple sites, and family therapy and relationship counseling to guide couples through changes in roles. Specifically, Cottone and Cottone concluded that:

> Children and spouses or mates should be involved in group meetings with rehabilitation counselors who communicate the goals and likely outcomes of successful rehabilitation programming. Family members should be made to feel they are "part of the team." They should know that the benefits of adaptation to the changes needed for successful rehabilitation will be greater than the detriments. They should be shown examples of successful cases so that they are aware of the opportunities provided by sociocultural transformation. And they should be given assistance when trouble arises, because real rehabilitation means effective intervention . . . (p. 23).

Clearly, it is incumbent upon rehabilitation professionals to remember that in providing services to persons with disabilities, "family members represent permanent natural supports and professionals provide temporary supports" (English, 1990, p. 11).

It is essential that rehabilitation professionals take seriously their responsibility to serve families when such services are necessary to ensure the vocational rehabilitation of American Indians with disabilities. In terms of developing of model of rehabilitation service delivery that is less client-focused and more family-focused, Leung (1993) commented that "the use of different models may bring about more efficient and perhaps more cost-beneficial rehabilitation efforts. These new models may rely less on a professional counselor initiating the change process and more on unleashing the powers of the cultural and social milieu to bring about change . . . . (p. 9).

Indeed, as regards the "power" of cultures, Triandis (cited in Westbrook & Legge, 1993) "described individualism--collectivism as the most promising dimension in accounting for cultural variations in social behavior" (pp. 178-179). The importance of family, as a representation of the value of the collective in American Indian cultures, has been powerfully described by Canoe (1993):

> As children grow up, you try to give them both systems--the traditional system, the Great Law, the ceremonies, and also you teach them the outside system. They need to know that, too, to survive. All you can do is you guide them. That's what parents are for. There's no way in the world I'm going to let my daughter go just because she's twenty-one. When I let go is when I die. I can't do otherwise. I'm very hard (p. 284).

In a study of 31 women with disabilities, ranging in age from 22 to 69, Nosek, et al. (undated), found that "coherence, self-regulation, competence, resilience, empowerment, and health awareness--resilience seem[ed] to be the most relevant to the results of this study. . . . The setting of boundaries . . ., lines of resistance and defense, emerged as an important part of this

resilience. These boundaries were constantly threatened by insensitive behaviors of medical professionals and *overwhelming overprotectiveness by family* for many participants" (p. 27; emphasis added). Thus, a significant question becomes: To what extent is "overwhelming overprotectiveness" pathological in cultural situations where such "protectiveness" is the community norm? According to Stewart (1972), "In the United States, individual achievement is usually valued above family relationships. In this respect . . . the American middle-class differs from most non-Western culture groups" (p. 11). Given that researchers studying disability may carry American middle-class values that indeed differ from many other cultures, including American Indian cultures, can it be possible to generalize research conducted through an individualistic values base to individuals whose values base is formed from the collective society?

METHODOLOGY

Population

The population surveyed included staff members from the 22 tribal VR projects (Section 130 projects) existent at the time of the research in 1994. According to Guy (1991), "in 1978, Congress enacted P.L. 95-602, amending the Rehabilitation Act of 1973 (P.L. 93-112), authorizing the funding of grants directly to the governing bodies of Indian tribes located on federal and state reservations for the purpose of providing VR services to American Indians with disabilities who live on reservations" (pp. 12-13). While tribal VR projects emulate most of the basic services provided through the public VR programs (administered through individual states), they also have the authority to offer "special VR services, such as ceremonial healing, which are unavailable from state agencies" (Guy, 1991, p. 14).

Of the 22 Section 130 projects, the directors of 18 (82%) agreed to participate. (Of the four directors who did not agree to participate, at least one said the reason was because his project was too new to provide any data). Of those directors who did agreed to participate, 10 (56%) completed an instrument designed to elicit information regarding general information in terms of both program and client characteristics; this instrument is referred to below as the *director survey*. In addition, 36 Section 130 project staff, including 11 directors, completed a *staff survey*, designed to elicit more specific information regarding services and supports provided to families. Including respondents to both the *director survey* and to the *staff survey*, 15 (83% of those who agreed to participate; 68% of all projects in 1994) tribal VR projects are represented in the research results.

Procedure

The research project was conducted as a mailed survey, with telephone follow-up as needed. Survey items included, for example, an assessment of how families were utilized as resources by project staff, to what extent families were provided with services, and what training needs project staff had as regards working with families (see Appendices A and B). A staff person from the Choctaw Vocational Rehabilitation Project, Ms. Lucille Thomas, served as a consultant throughout the research process. Additionally, the survey instrument was developed in conjunction with a project advisory committee (PAC) (see Acknowledgments).

As a first step in the research process, directors of tribal VR projects were contacted by telephone and by letter; their participation in the research effort as both subjects and as members of the PAC was requested. Information regarding any necessary tribal approvals to conduct research was also obtained at the time of the initial contact. PAC members were asked to contribute

items for the survey instruments. Drafts of the proposed survey instruments were mailed during Spring 1994 to PAC members, interested directors, and to the research consultant; their feedback included several suggestions for changes/revisions in the instruments.

The pilot-test. Arrangements to conduct a pilot-test of the survey were made by Ms. Thomas and through Ms. Mary Meruvia, director of the Choctaw VR project. Ms. Meruvia asked, for example, whether only staff funded by Section 130 moneys should be requested to complete the survey, or if all staff who contributed to the Choctaw VR program should complete the survey. It was decided that all VR staff would complete the survey, regardless of the funding source of their position. As a result of the pilot-test, a question was added to the survey instrument in order to distinguish between such staff. After Choctaw staff completed the pilot-test, a debriefing session facilitated by Ms. Thomas was held in order to obtain feedback both on the content of the survey instrument as well as on the process/procedures involved in completing the survey. Feedback from this session was provided to the researchers by Ms. Meruvia; for example, some staff were concerned that questions did not apply to them, i.e., questions regarding size of caseload for persons who did not carry caseloads, such as industrial trainers. Minor changes in the survey instrument were made as a result of the pilot-test; additionally, staff participating in the pilot test recommended that researchers lengthen the amount of stated time it should take to complete the survey instrument. Of concern was the belief expressed by Ms. Meruvia that the *staff survey* was perhaps biased toward positive use of families, and that, consequently, staff would be afraid to answer in the negative.

The survey. On June 13, 1994, a letter was sent to the PAC, as well as to all tribal VR project directors informing them of the plan to distribute the survey instruments. On June 27, 1994, the final version of the survey instrument was mailed to those project directors who had agreed to participate, with the request to distribute the instruments to project staff. PAC members participated in conference calls with researchers on Wednesday, August 31, 1994 in order to discuss strategies for follow-up. It was the consensus of the participating PAC members that an adequate response rate had been obtained for the survey and that further follow-up was not necessary; however, researchers did fax a follow-up letter to non-respondents, offering them a final opportunity to contribute to the survey.

Analysis of data. Both qualitative and quantitative data were subjected to analyses. During September 1994, the survey data were entered into a database, cleaned, and verified. After verification, the quantitative data were analyzed using *SPSS for Windows* (1994); qualitative data were analyzed utilizing *HyperQual* (Padilla, 1991).

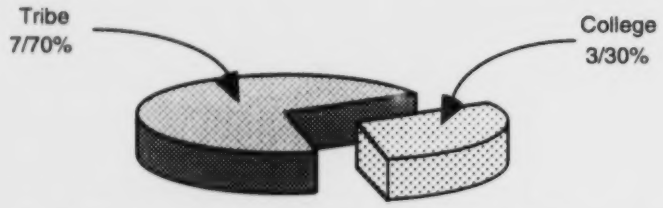
RESULTS

Director's Survey

Program Characteristics

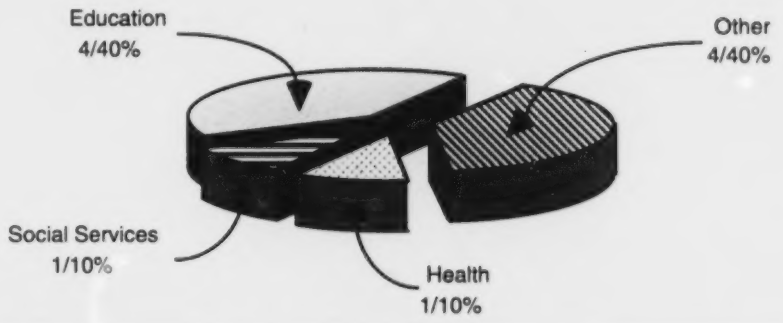
Respondents to the *director survey* (n=10) reported that their projects had been in existence, on average, for 4 years, with a range from 1 to 7 years. Tribes operated the majority of the projects (see Figure 1).

Figure 1
Operation of Program
(N=10)



While 100% (10) of the projects were funded through federal (Section 130) dollars, 50% (5) of the projects also reported receiving tribal monies. Specifically, 80% (8) of the projects received 80% or more of their funding from Section 130 dollars; only 20% (2) reported full funding from Section 130 dollars. The plurality [40% (4)] of projects were administered through tribal departments of education (see Figure 2), and served communities of up to 10,000 residents [50% (5)]. Three projects (30%) served communities of up to 5,000 residents and two projects (20%) served communities of up to 25,000 residents.

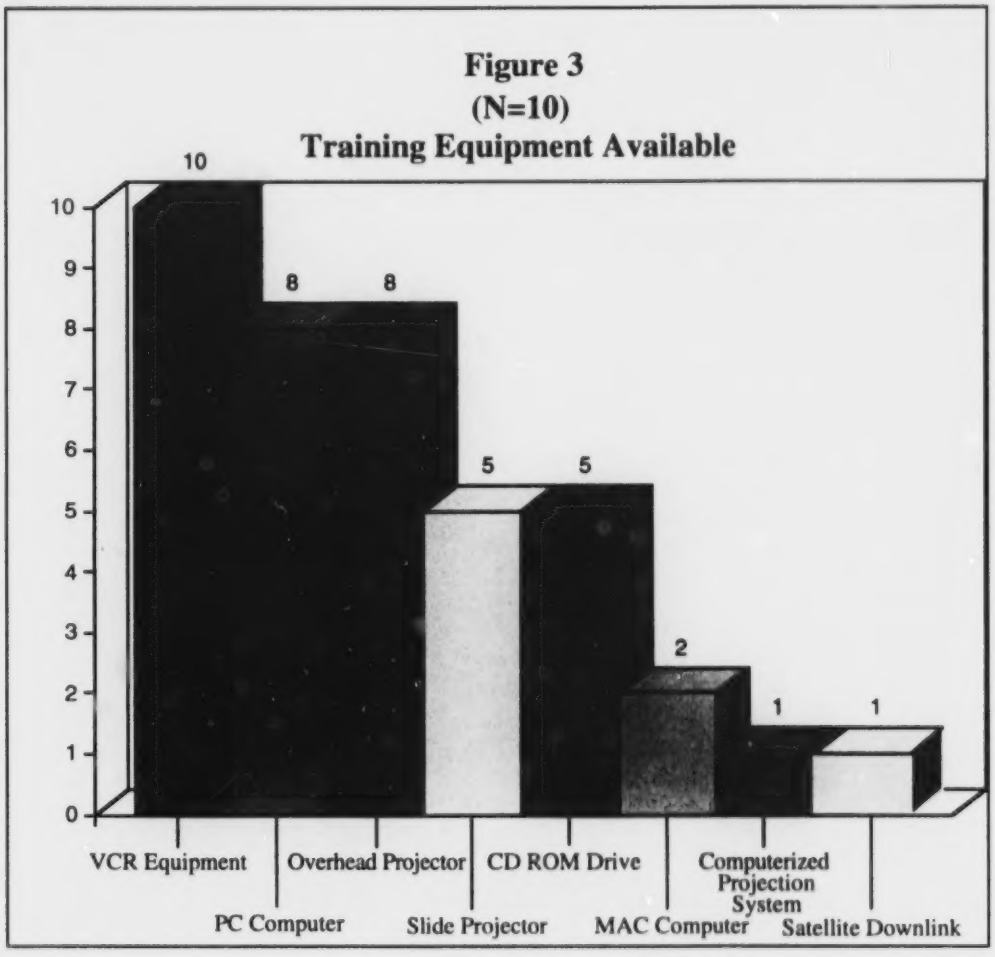
Figure 2
Administrative Unit Base
(N=10)



The majority [80% (8)] of responding directors reported having up to 5 staff funded through Section 130 dollars, with 20% (2) of the directors reporting that up to 10 staff were funded through Section 130 dollars. The plurality [40% (4)] of respondents reported that up to 5 staff were funded through other sources. On average, directors reported that 33 clients were assigned to each counseling staff, with a range of between 15 and 50 clients.

In responding to four Likert-type items, the majority [90% (9)] of directors *strongly agreed/agreed* that they encouraged staff to involve the family in all aspects of the rehabilitation process, while 80% (8) *strongly agreed/agreed* that their facility was "well-designed" to support interaction with the family members of clients. Only 40% (4) *strongly agreed/agreed* that they had provided opportunities for staff to participate in training related to family issues; however, 80% (8) *strongly agreed/agreed* that they would support opportunities for staff members to attend any such future training.

Equipment available within the projects for the delivery of training is presented in Figure 3.



Client Characteristics

On average, the projects each had served 82 clients in the past year, with the plurality [40% (4)] citing alcohol/substance abuse as the most common disabling condition among their clients. This plurality was followed by mental retardation, diabetes, and orthopedic impairments (see Table 1). Responding directors reported that 100% of their clients were

Table 1
Primary Disabling Conditions: *Director's Survey*
(N=10)

Disabling Condition	1st Most Common	2nd Most Common	3rd Most Common
Alcohol/ Substance Abuse	40%	20%	----
Mental Retardation	20%	----	----
Diabetes	10%	10%	10%
Orthopedic Impairment	10%	----	20%
Learning Disability	----	20%	30%
Arthritis	----	10%	----
Emotional Disability	----	10%	----
Heart Disease	----	----	10%
Developmental Disability	----	----	10%

American Indian or Alaska Native. In all cases, the majority of clients served by a given tribal VR project were affiliated with the tribe associated with the project; a maximum of 10 -15% of the client populations included persons of other tribal affiliations. The majority [60% (365)] of clients served were males (see Figure 4). The plurality [40% (4)] of responding directors reported that

their clients traveled, on average, 21 - 50 miles in order to receive services (see Figure 5), with a median of 13% living alone.

Figure 4
Sex of Clients
(N=10)

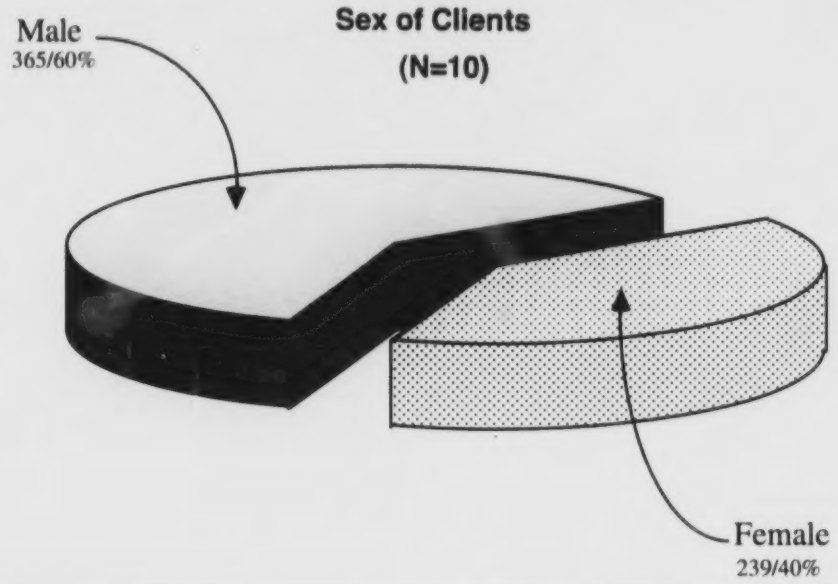
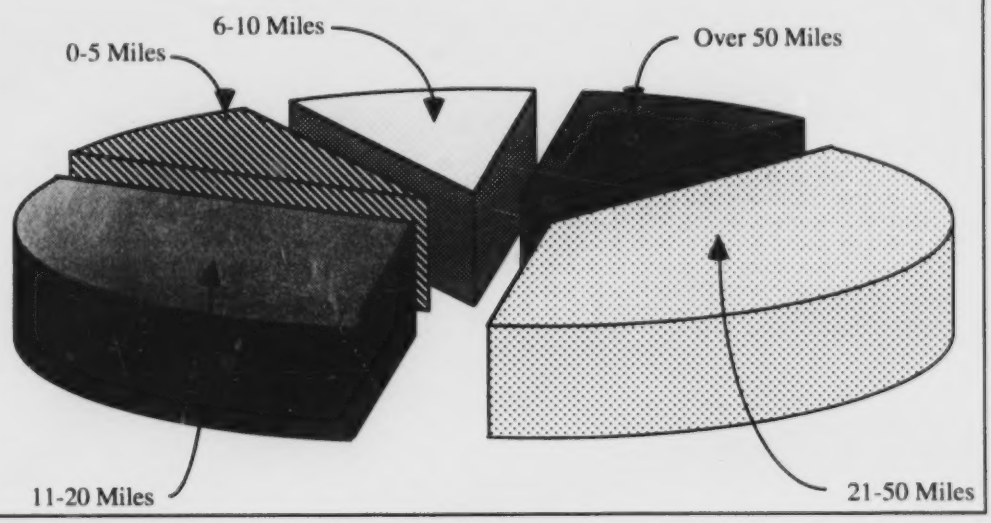


Figure 5
Distance Clients Travel for VR
(N=10)



Labor Market Resources

Responding directors reported a wide range of unemployment in the communities they served, from 6% to 90%, with a median unemployment rate of 49%. Employment opportunities were reported to be concentrated in services areas such as health care and tourism (see Table 2), and were reflected in reported closures (successful placement for employment) (see Table 3).

Table 2
Local Employment Opportunities

Area of Opportunity	Frequency by Project	Median % of Labor Market
Health Care	6	10%
Tourism	5	15%
Education	5	12%
Human Services	5	12%
Professional	5	10%
Industrial*	5	5%
Sales	4	6%
Agriculture	4	4%
Self-employment	3	10%
Clinical	3	3%

*Note: Carried greatest range, i.e., from 1% - 75% of labor market opportunities

Table 3
Closures in Past Year

Area of Closure	Frequency by Project	Median % of Closures
Service	6	11%
Clerical	6	10%
Self-employment	4	11%
Homemaker	4	10%
Sales	4	8%
Agricultural	4	6%
Student/Trainee	3	5%
Professional	3	6%
Industrial	2	6%; 85%
Sheltered Workshop	1	15%
Unpaid Family Worker	1	1%

Staff Survey

Of those persons responding to the *staff survey*, the majority [83% (30)] were American Indian or Alaska Native, with 17% (6) being Caucasian, not of Hispanic Origin (see Figure 6). Staff were equally divided between males and females (see Figure 7). Staff had an average age of 38; however, the plurality [42% (15)] of staff ranged in age from 40 - 49 years (see Figure 8).

Figure 6
Ethnicity of Staff
(N=36)

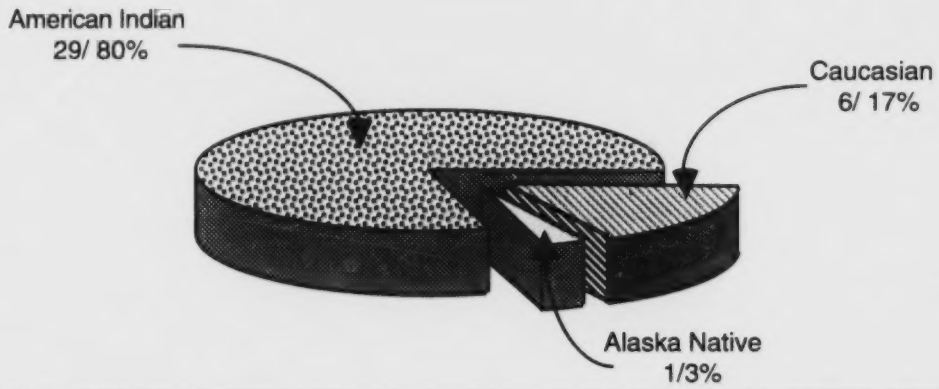


Figure 7
Sex of Staff
(N=36)

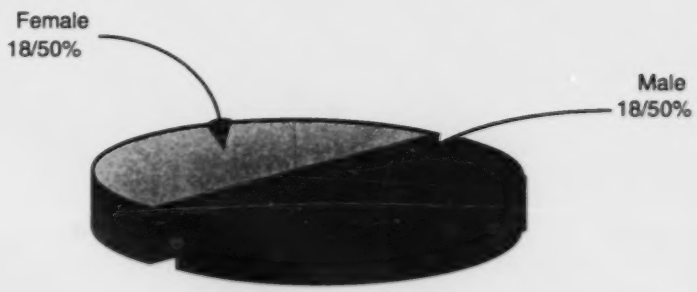


Figure 8
Age of Staff
(N=36)

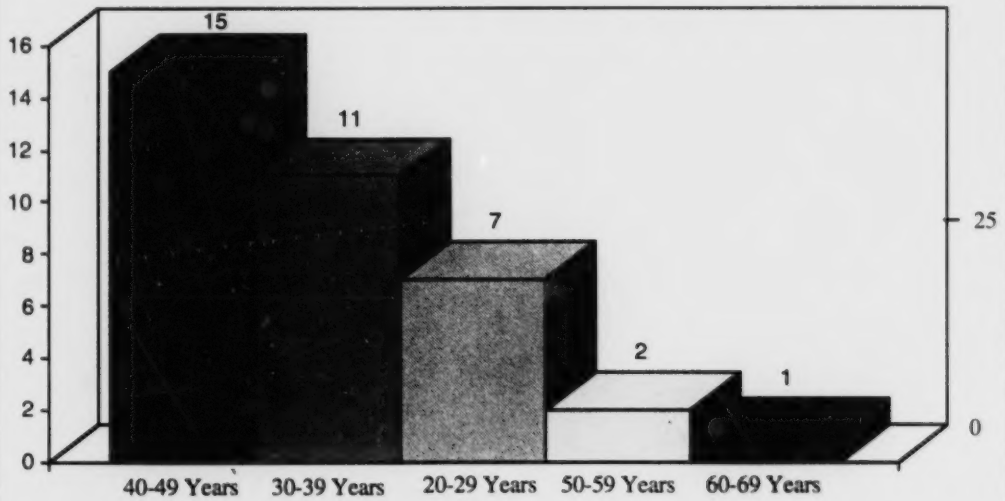
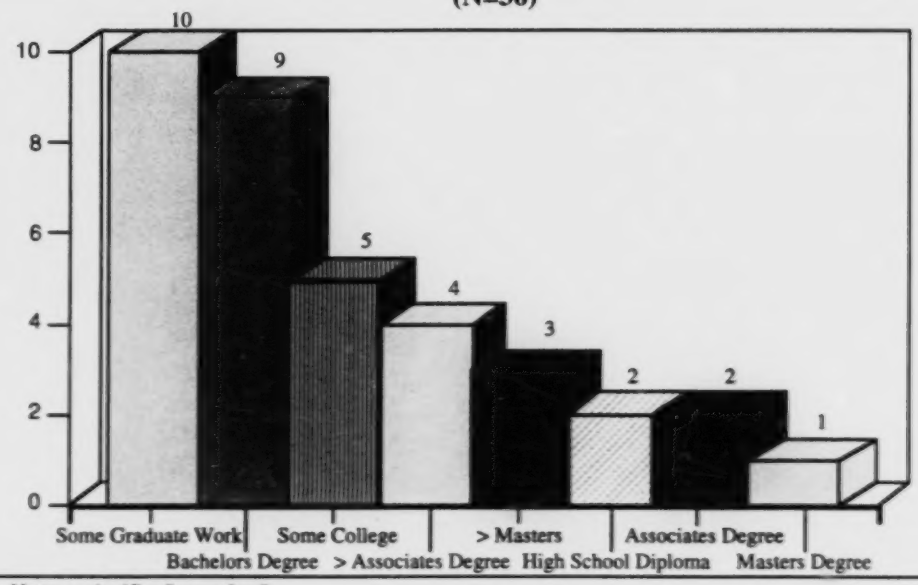


Figure 9
Education Level of Staff
(N=36)



Note: > signifies "more than"

The plurality [28% (10)] of all staff reported having completed some graduate work, followed by those who held a bachelor's degree [25% (9)] (see Figure 9). The plurality [42% (15)] had held their position less than one year (see Figure 10); the plurality [31% (11)] had also worked in the rehabilitation profession for less than one year. A large majority [83% (30)] had worked in the rehabilitation profession for five years or less (see Figure 11).

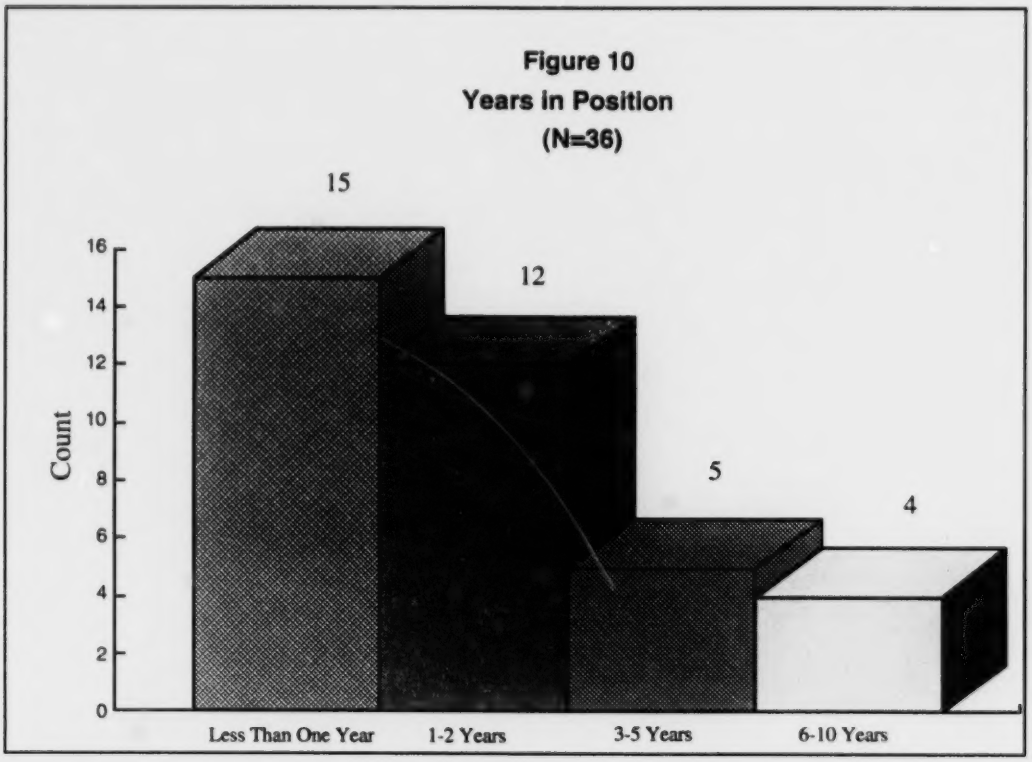
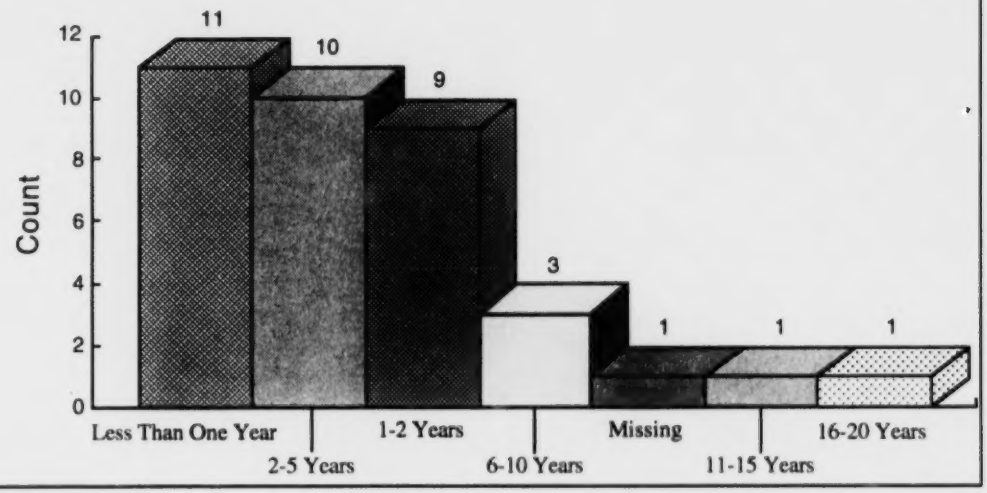


Figure 11
Years In Rehabilitation Field
(N=36)



The majority [92% (33)] of all staff held full-time positions (see Figure 12). Of those persons responding to the *staff survey*, the majority [61% (22)] were principally engaged in the delivery of direct services, while 31% (11) served as the director of the tribal VR project (see Figure 13). Half [50% (18)] of the respondents reported having supervision responsibilities and supervised an average of 2.8 persons [range: 1-14]. The mean hours per week spent on the *primary* work responsibilities of staff are presented in Figure 14.

Figure 12
Staff Hours Worked Per Week
(N=36)

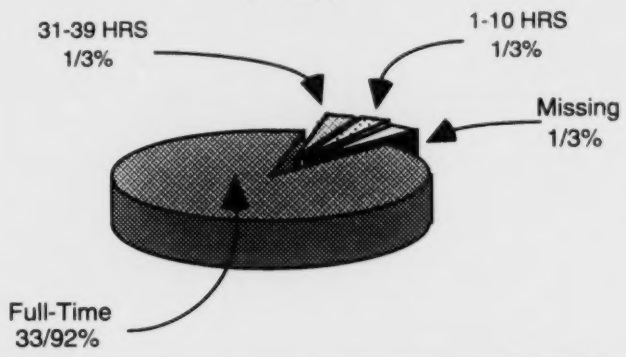


Figure 13
Categories of Respondents to
Staff Survey
(N=36)

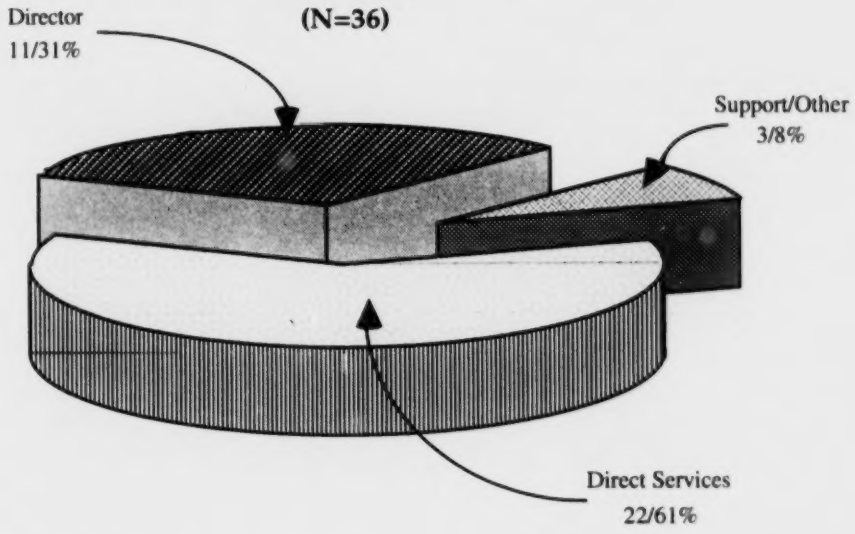
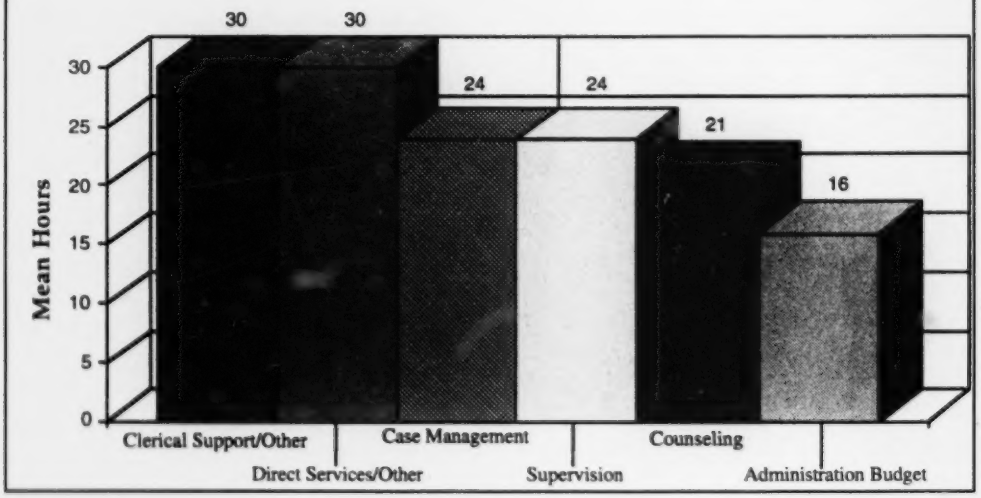
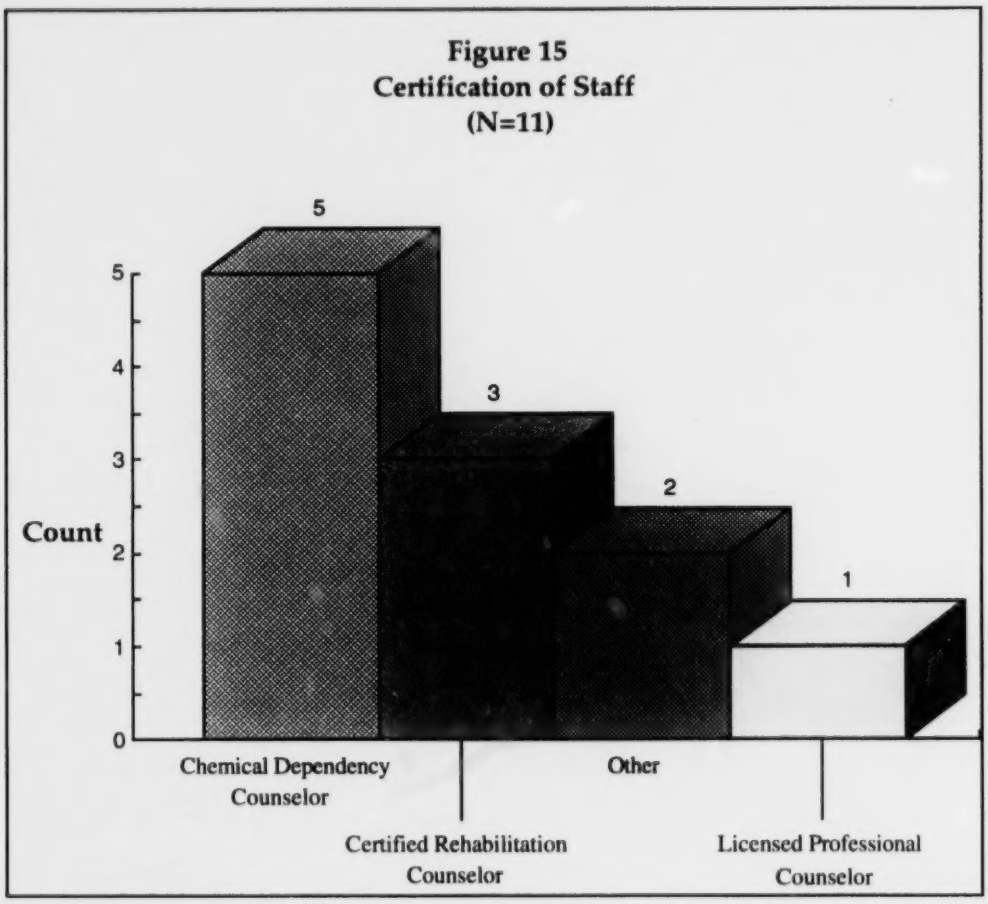


Figure 14
Mean Hours per Week
Spent On *Primary* Work Responsibilities



Of those persons either engaged in direct services or serving as director (n=33), one-third [33% (11)] reported having some form of professional certification (see Figure 15).



Demographic Information Specific to Directors

Of the 11 directors responding to the *staff survey*, the majority [64% (7)] were male; the majority of directors [64% (7)] were also American Indian. The directors were, on average, 41 years of age, with the plurality [46% (5)] reporting that they had completed some graduate work. Areas of education included: vocational rehabilitation, social work, psychology, education, industrial arts, and sociology. Three (27%) of the directors were certified rehabilitation counselors. Additional areas of training and expertise included: tribal court advocate, counseling, mental health, alcohol and drugs,

teaching certificate, program administration, grant writing, and vocational evaluation.

The plurality of directors [46% (5)] had held their current position for between 1 - 2 years, followed by more that a third [36% (4)] who had had their position for less than one year. The plurality of directors [36% (4)] had worked in the rehabilitation profession for 2 - 5 years, followed by just over a quarter [27% (3)] who had worked in the profession for 1 - 2 years. On average, directors reported supervising 4 staff; the majority [64% (7)] did not report having any clients assigned to them.

Demographic Information Specific to Direct Services Staff

Direct services staff (N=22) were equally divided between females [50% (11)] and males [50% (11)], were predominately American Indian or Alaska Native [95% (21)], and were an average of 37 years old. The plurality [32% (7)] reported having a bachelor's degree, followed by those who had completed some graduate work [23% (5)] or some college [23% (5)]. Areas of education included: social work, rehabilitation, general studies, human services, and counselor education. None were certified rehabilitation counselors. However, other areas of training and expertise included: addiction counseling, fetal alcohol syndrome, chemical dependency, nurse's aid, and supervision in manufacturing. The plurality [41% (9)] of direct services staff reported having been in their current positions for less than one year; the plurality [36% (8)] also reported having worked in the rehabilitation profession for less than one year.

Services Provided by Direct Services Staff

On average, direct services staff reported being assigned 36 clients, and reported dealing primarily with persons having, for example, alcohol or substance abuse disorders, learning disabilities, and diabetes (see Table 4). Services provided to *individual clients* are listed in Table 5.

Table 4
Primary Disabling Conditions: Direct Services Staff
(N=22)

	Percent Ranking As		
Disabling Condition	**1st Most Common**	**2nd Most Common**	**3rd Most Common**
Alcohol/ Substance Abuse	46%	14%	18%
Learning Disability	14%	23%	23%
Hearing Impairment	9%	----	----
Orthopedic Impairment	9%	5%	9%
Arthritis	5%	9%	5%
Diabetes	5%	27%	14%
Mental Retardation	5%	5%	----
Emotional Disability	----	5%	----
Paralysis	----	5%	----
Heart Disease	----	----	5%
Severe & Persistent Mental Illness	----	----	5%

Table 5
Services Provided to Individual Clients by Direct Services Staff
(N=22)

Service Provided	Mean Average*	Rank
Counseling and Guidance	1.45	1
Eligibility Assessment/ Intake	1.82	2
Education Training	2.10	3
Assessment of Personal Situation	2.14	4
Case Management and Referral	2.14	4
Transportation	2.18	5
Vocational Assessment	2.20	6
Rehabilitation Orientation	2.24	7
Assessment of Disability Status	2.27	8
Job Placement and Referral	2.33	9
Rehabilitation Planning (IWRP)	2.33	9
Home Visitation	2.36	10
Utilizing Informal Supports	2.52	11
Work-site Visitation	2.54	12
Post-Employment Services	2.71	13
Business/Vocational Training	2.90	14
Financial Assistance	3.00	15

Table 5
Services Provided to Individual Clients by Direct Services Staff
(N=22)
(continued)

Service Provided	Mean Average*	Rank
Physical Restoration	3.10	16
Financial Planning	3.19	17
On-the-Job Training	3.19	17
Supported Employment	3.20	18
Advocacy	3.32	19
Activities of Daily Living Training	3.57	20
Family Counseling	3.67	21
Child Care	3.73	22
Assistive Technology	3.76	23
Native Healing/Counseling	3.76	23
Interpretation (Native Language, ASL)	3.81	24
Modification of Housing for Access	3.95	25
Independent Living	4.05	26
Group Therapy	4.40	27

*Note: 1 = Always/Usually; 3 = Sometimes; 5 = Rarely/Never

Inclusion of the Family in VR Services

Services provided by direct services staff in which *family members were involved* are listed in Table 6. Family members *included* in particular

services are listed in Table 7. Assessments made by direct services staff in regard to potential supports provided by family members are listed in Table 8.

Table 6
Services in which Direct Services Staff Involved Families
(N=22)

Service	Mean Average*	Rank
Transportation Services	3.09	1
Home Visitation	3.18	2
Information about Disabling Condition	3.19	3
Client Eligibility Assessment	3.29	4
Rehabilitation Orientation	3.29	4
Involvement in Job Placement	3.48	5
Utilizing Informal Supports	3.48	5
Assessment of Family Needs	3.67	6
Family Case-Management & Referral	3.67	6
Involvement in Training Planning	3.67	7
Planning for Future Care of Consumer	3.67	8
Integration of Assistive Technology	3.70	9
Involvement in Post-Employment Services	3.76	10
Assessment of Family Expectations	3.86	11

Table 6
Services in which Direct Services Staff Involved Families
(N=22)
(continued)

Service	Mean Average*	Rank
Participation in IWRP Planning	3.86	11
Skill Training in Personal Assistance	3.86	11
Diagnosis & Evaluation	3.95	12
Financial Assistance to Families	4.05	13
Financial Planning	4.05	13
Interpretation (Native Language, ASL)	4.05	13
Modification of Housing for Access	4.05	13
Native Healing or Counseling	4.05	13
Planning for Independent Living	4.05	13
Child Care Services	4.09	14
Advocacy for Family Members	4.14	15
Family Counseling & Progress Reviews	4.14	15
Multiple Family Support Group	4.52	16
Respite Care Services	4.90	17

*Note: 1 = Always/Usually; 3 = Sometimes; 5 = Rarely/Never

Table 7
Family Members Receiving Assistance by Direct Services Staff
(N=22)

Family Member	Staff Providing Service %(#)	Services Provided: Child Care	Transportation	VR Orientation	Counseling	Advocacy	Mental Health Referral	Education Referral	Other Referrals	Follow-up	IWRP
Spouses	36% (8)	x	x	x	x		x				
Mothers	23% (5)	x			x	x	x		x	x	x
Daughters	23% (5)	x	x		x	x		x	x		
Sons	23% (5)	x	x		x	x		x	x		
Boy/ Girlfriends	23% (5)	x	x	x	x	x	x	x	x		
Sisters	18% (4)	x	x		x	x	x		x		
Brothers	18% (4)		x		x	x					
Fathers	18% (4)			x	x	x			x	x	x
Friends	18% (4)	x	x	x	x	x	x		x		
Grandmothers	14% (3)	x	x	x		x	x		x		
Grandchildren	9% (2)				x	x		x	x		
Cousins	9% (2)	x	x			x	x	x	x		
Nephews/Nieces	9% (2)				x	x		x	x		
Uncles	9% (2)	x	x			x	x	x	x		
Aunts	5% (1)					x		x	x		
Mothers-in-law	5% (1)					x			x		
Fathers-in-law	5% (1)					x			x		
Grandfathers	5% (1)					x			x		

Table 8 Typical Assessments Made by Direct Services Staff (N=22)		
Area of Family Assistance	**Staff Making Assessment % (#)**	**Rank**
Transportation	91 (20)	1
Mobility Assistance	77 (17)	2
Developing Educational Skills	59 (13)	3
Developing Social Skills	59 (13)	3
Interpretation (Native Language, ASL)	59 (13)	3
Shopping/Home Maintenance	59 (13)	3
Bathing & Personal Assistance	55 (12)	4
Developing Job Skills	50 (11)	5

Institutional Capacity for Family Involvement

Respondents to the *staff survey* were asked to respond to broad systemic questions in regard to institutional support for family participation in the rehabilitation process. An analysis of variance (ANOVA) was conducted in order to test for any statistical differences between the mean responses of directors and the mean responses of direct services staff (see Table 9). Respondents to the *staff survey* also were asked to describe their

perceptions and beliefs regarding family involvement in the rehabilitation process. Again, an ANOVA was conducted in order to test for any statistical differences between the mean responses of directors and the mean responses of direct services staff (see Table 10). Finally, respondents were asked to assess the importance of family member's participation in seven key elements typically found in the rehabilitation process (see Table 11); there were no statistical differences between the responses of directors and the mean responses of direct services staff.

Table 9
Structures and Processes Allowing for Family Involvement
(N=33)

Institutional Supports	Rank**	Staff Mean Response*	Director Mean Response*
I am satisfied with our agency's activities in regard to encouraging family involvement.	1	4.00	3.91
Family needs and issues are frequently discussed during case staffing sessions.***	2	3.64	4.82
My schedule allows me to visit families in their homes to assess their needs.***	3	3.45	4.60
It is possible to record when services to families have been provided using my agency's status code system.***	4	3.36	2.09
Our facility is adequate in size and space to regularly accommodate family members in the rehabilitation process.	4	3.36	3.55
My agency offers orientation sessions to family members, consumers, and others about the range of rehabilitation services.	5	3.27	4.27
My schedule allows me to work with families in various aspects of the rehabilitation process.***	6	3.18	4.60
My agency has outlined policy and procedures for encouraging greater family participation.	7	2.82	3.73
Our center has the capacity to transport family members from their homes so that they may be included in the rehabilitation process.	8	2.73	2.45

*Note: 1 = Strongly Disagree/Disagree; 3 = Neutral; 5 = Agree/Strongly Agree
**Rank is in order of Staff Mean Response
***$p < .05$

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Table 10
Attitudes Regarding Family Involvement
(N=33)

Perception/Belief	Rank**	Staff Mean Response*	Director Mean Response*
Participation of the consumer's family in various aspects of the rehabilitation process can improve the client's opportunities for successful vocational outcome.	1	5.00	5.00
I believe in the importance of taking steps to involve the family to the fullest extent in the client's rehabilitation program.	2	4.90	5.00
Extended family members should be invited to participate in the rehabilitation programs of clients.	3	4.40	3.73
My co-workers express positive support for including families in the rehabilitation process.***	4	4.10	5.00
My supervisor encourages me to involve families in the rehabilitation process.	5	4.00	4.33
Consumers are generally supportive of any efforts to include key members of their family in their vocational rehabilitation program.	6	3.60	4.20
Participation of the consumer's family in various aspects of the rehabilitation process can hinder the client's opportunities for successful vocational outcome.	7	3.24	2.64
Family members are not typically interested in participating in their relative's VR program.	8	3.20	2.82

*Note: 1 = Strongly Disagree/Disagree; 3 = Neutral; 5 = Agree/Strongly Agree
**Rank is in order of Staff Mean Response
***$p < .05$

Table 11
Importance of Family Involvement in Key VR Services
(N=33)

VR Service	Rank**	Staff Mean Response*	Director Mean Response*
Initial Client Orientation	1	4.43	4.60
Assessment of Personal Situation	2	4.40	4.64
Rehabilitation Planning (IWRP)	3	4.24	4.27
Placement	4	4.20	3.55
Vocational Assessment	5	4.14	3.91
Follow-up	6	4.05	3.73
Eligibility Assessment	7	3.90	3.18

*Note: 1 = Not Important; 3 = Neutral; 5 = Very Important
**Rank is in order of *Staff Mean Response*

Respondents to the *staff survey* were asked to determine to what extent they **regularly assessed** ways in which the family could be utilized as a resource and/or included in the rehabilitation process; an ANOVA was conducted in order to test for any statistical differences between the mean responses of directors and the mean responses of direct services staff (see Table 12).

Table 12
Assessments Related to Family Inclusion
(N=33)

Item Assessed	Rank**	Staff Mean Response*	Director Mean Response*
Potential Barriers to Family Participation	1	2.24	2.40
Family History	2	2.27	1.40
Existing Systems of Informal Support	3	2.40	1.40
Names and Roles of Key Family Members Who Provide Assistance***	4	2.50	1.00
Amount of Family Involvement Desired by Client	5	2.62	1.80
Existing Systems of Formal Support***	5	2.62	1.20
Role of the Extended Family in Client's Life***	6	2.71	1.20
Needs of Family Members	7	2.73	2.60
Family Expectations of the Rehabilitation Process	8	3.00	2.60

*Note: 1 = Always/Usually; 3 = Sometimes; 5 = Rarely/Never
**Rank is in order of Staff Mean Response
***$p < .05$

Barriers to Family Involvement

Barriers to the effective involvement of family members in the rehabilitation process are listed in Table 13. An ANOVA was conducted in order to test for any statistical differences between the mean responses of directors and the mean responses of direct services staff. A statistical difference between mean responses was found only with the item "Lack of Support from Supervisor" ($p < .05$).

Table 13
Barriers to Family Involvement
(N=33)

Barrier	Rank**	Staff Mean Response*	Director Mean Response*
Lack of Family Transportation	1	1.57	1.89
Lack of Family Knowledge about VR Process	2	2.05	2.33
Lack of Time/Scheduling	3	2.40	1.89
Lack of Client Awareness of Policies	4	2.50	2.78
Lack of Family Expectation that They Should be Involved	5	2.50	3.22
Budget Limitations	6	2.80	2.80
Resistance from Family Members	7	2.80	2.56
Inadequate Space for Family Meetings	8	3.00	2.56
Lack of Child Care	9	3.19	3.44
Lack of Agency Policy or Procedure	10	3.20	3.89
Lack of Counselor Awareness of Policies	11	3.50	3.67
Size of Caseload	12	3.53	3.67
Lack of Support from Supervisor***	13	3.60	4.78
Lack of Counselor Expectation that Family Would be Involved	14	3.70	3.80

Table 13
Barriers to Family Involvement
(N=33)
(continued)

Barrier	Rank**	Staff Mean Response*	Director Mean Response*
Language Differences	13	3.86	4.56
Lack of Counselor Incentive	14	4.00	4.33
Inability of Counselor to do Home Visits	15	4.20	4.56
Lack of Reward to Counselor	15	4.20	5.00
Lack of Building Accessibility	16	4.30	4.11
Counselor Hesitant to do Home Visits	17	4.50	4.56

*Note:1 = Always/Usually; 3 = Sometimes; 5 = Rarely/Never
**Rank is in order of Staff Mean Response
***$p < .05$

Qualitative Data

Overview

There were 27 (75%) informants who responded to either all or some of the 10 qualitative (open-ended) questions on the survey instrument. Preliminary analyses of the answers revealed respondents to be fairly consistent with their remarks. For example, in response to the question, "How would you define "family" with respect to American Indian/Alaska Native clients?," the concept of "family" was generally defined to include

"blood" relations and extended family, which may or may not include close friends or other people who are supportive of the individual. "Family" was frequently described as a unit grouped together out of necessity for survival (economic and emotional) and support.

In regard to the question, "What is your understanding of the tribal vocational rehabilitation services that can be provided to the family members of your clients?," responses included such options as child care, financial assistance, education, home modifications, counseling, emergency assistance, and referral services. Additionally, respondents often stated such services were available only to immediate family members.

In regard to the question, "How would you like to see the family involved in the rehabilitation process?," almost all responses depicted the ideal role of the family as being supportive of the client and of the rehabilitation program. Some respondents noted that family members were sometimes unavailable for support to the client because of their own problems. In particular, when asked to describe a situation from their experience where family involvement negatively influenced the client's rehabilitation, alcohol dependency among family members was mentioned most frequently. For example, one respondent commented: *"I believe one of the most negative situations and most widespread is the sober client living with a using family."*

Section 130 staff were asked to identify barriers they had experienced in providing adequate services to families. Barriers mentioned most often included: transportation, language, inadequate funding, apathy or non-compliance, and lack of facilities. Other responses included mention of alcohol abuse, negative attitudes (of family), and lack of cultural awareness on the part of the service providers. Staff suggested that these barriers could

possibly be overcome with more funding, more education (for family and providers), more facilities, and more support staff.

In response to the question, "How would you design a rehabilitation system which focused on the needs of the family in addition to the needs of the individual?," the emphasis of respondents was on more fiscal resources, as well as training for service providers and for family members. Improved facilities were thought to be essential to including families in individual rehabilitation programs, with education of family members mentioned frequently. Implementation needs for such a system included: money, staff, community involvement, and more physical space in which to hold training sessions.

Respondents were asked to describe a situation from their experience in which family involvement had negatively influenced the client's rehabilitation. Many informants described situations in which the individual failed to follow through on the rehabilitation program due to the influence of a family member. Alcohol dependency was mentioned most frequently.

Finally, respondents generally agreed that the family was most important in the rehabilitation of individuals. Education of family members was stressed along with the inclusion of family members in the VR process.

Definition of Family

Respondents to the question asking for a definition of the term "family," when used in respect to Indian/Alaska Native clients, with one exception, defined an entity which included at a minimum those persons related by blood. Eight respondents used the word "blood" as part of their definition. Almost a third [32% (9)] of the respondents included the term "extended family" when identifying a family by American Indian/Alaska Native standards. Five respondents identified fairly identical lists of who is

included when extended family terminology is used. Typical of these five respondents was the following: *"The family includes the grandparents, aunts, uncles, nieces nephews, cousins, and in-laws."*

Support and survival unit. Eleven respondents (39%) broadened the definition of family to include a culturally-derived concept of support and survival. The definitions offered by these individuals included a broader range of persons which might include people outside the dominant society definition of extended family. For example, one respondent within this group described the family as, "*A unit depending on each other for survival.*"

Four respondents stressed the culturally-sanctioned responsibility to provide for others as a necessary consideration in defining family:

> *"To me Native Americans have deep roots and values that precede way back in time. They were taught to protect, provide, and maintain stability for all members of their kin. Family is upheld as most important for most all Native Americans that I know, no matter what the price."* (Support staff/other)

> *"Family in the Native American clients are traditionally the backbone of their lives. They rely on them for emotional support and many times financial support."* (Direct services)

> *"Family can mean any blood relative ([including] extended family), [or] village member who has close ties to the family; any person within a group who helps to ensure each other's safety and well-being."* (Direct services).

"Family - anyone or every member of the family would help one another, no matter what the situation is." (Direct services)

Two respondents included an explanation of the inclusion of people as relatives who are not traditionally defined as such in dominant society families. Their definitions stated, "*Any person related by blood, taken as a relation in a traditional manner, or a person that has lived in the family structure for an extended period of time,*" and, similarly, "*anyone related by blood as in a traditional manner or that has lived with the family for a long time.*"

VR Services to Families

Six of the 11 project directors (55%) answered the question regarding what tribal VR services can be provided to family members with responses that affirmed providing services to family members when services would increase the likelihood of a successful rehabilitation for the client. One director responded, *"Services to family members can be provided if it will help the client reach the vocational goal."* A second director answered, *"Whatever it takes to complete objectives and get client a job."* Examples of services listed were: counseling, referral, education, family assessment, emergency assistance, home modifications, technology, financial assistance, and inclusion in the various stages of the rehabilitation process. One director qualified eligibility of family members to receive services with the following statement, *"We consider this limited to immediate family (son/daughter/ spouse) for expenditures."*

Three (3) responses to this question came from staff in Section 130 projects that performed clerical support or other functions. Two of the three responded that tribal VR services attempted to maximize supports for the

client by assisting the family; for example, *"Voc. Rehab. services try to give the whole family the encouragement and help, to find ways to produce productive, active people for the betterment of themselves and everyone they become involved with."* The third respondent in this category narrowed the services provided to families to three: maintenance, transportation, and limited child care, stating *"More substantial direct services would indicate that family members probably needed to apply for services themselves, or they may be referred to a more appropriate service providers."*

A majority of the direct services staff [77% (17)] responded to this question with answers varying a great deal in terms of what respondents felt were allowed services that could be provided for the family members of a VR client. Five direct service staff responded that VR services were, in fact, limited only to the client. Counseling and family education were the most often mentioned services that were allowed. A tentative quality was reflected in some responses to this question, with qualifying initial clauses such as, *"I am not fully aware of services that can be provided to the family through VR,"* or *"My understanding of it would be things like child care referrals or other agencies and any other needs of the family."*

Role of the Family in the Rehabilitation Process

Twenty-five (25) responses were received for the question, "How would you like to see the family involved in the rehabilitation process?" Fourteen (14) respondents used the term "support" or "supportive" in describing the ideal family role. Nineteen (19) respondents wanted to see family involvement throughout the rehabilitation process. Still another respondent summed up the role of family in the following way, *"Top--most important to successful rehabilitation of client--VITAL!!"* Two respondents questioned family ability to be appropriately involved: *"85-90% of the families*

are unable to give support because they themselves are emotionally dysfunctional and/or chemically dependent," and *"It might be useful to have a separate orientation for family (spouse). That might give a clearer indication of how supportive they actually are."*

Barriers to Providing Adequate Services to Families

Twenty-four (24) of the respondents identified barriers to providing adequate services to families. A compilation of these barriers revealed the following responses (see Table 14):

Table 14
Barriers to Providing Family Services

Problem	Frequency
Transportation (vehicles, weather, roads)	13
Lack of intimated interest on behalf of family	9
Detrimental/dysfunctional behaviors (family)	7
Controlling behaviors (family)	6
Counselor case load too large (no time)	6
Language/communication barrier	5
Lack of funds/resources	5
Lack of policy/program initiative to encourage	4
Lack of time due to family work hours	4

When the suggestions of 26 respondents for overcoming barriers to delivery of services to family members were tabulated, the following items listed in Table 15 received the most support:

Table 15
Overcoming Barriers to Serving Families

Suggestion	Frequency
Family education (VR process regarding available services)	10
Education of VR staff (allowable services)	9
Emphasis/outreach to family	8
Targeted interviewing of client for family needs related to VR process	4
Funding for family	4
Follow clients closely to identify when family needs dovetail with VR needs	4

One respondent summarized: *"Definitely training on how families can benefit from the VR process which would include examples of what other programs are doing in this area. I am interested in knowing what are the specific services that can be provided without necessarily making other family members eligible, individually."*

Positive Contribution Made by Family

Of the 20 respondents to a question regarding positive family contributions, 16 provided a success story. Two respondents answered that the programs in which they work were new and they had not yet had the

opportunity to get a client to the stage to have a success story. Only one respondent answered, *"[I] have never had a family get involved with the client."* The following four cases represent positive closures with employment as an outcome.

Case #1 *...a man about 30 to 35. Alcohol was the problem and the family helped in every way. They attended AA meetings, counseling meetings, Al-Anon meetings and stood by his side in every way. This man is now in a job situation and has been successful and is a good tribal member.*

Case #2 *Closed head injured client. 16-year old male. Personality change, financial devastation on family. Many years of PT, OT & ST to regain at least 75% of loss. Single parent home. Mother loses job while child is in therapy. No income. Lawyers involved - lawsuit. Once client completed therapy mother went to work. Son completed H.S. Attended head injury support groups, counseling for all family members to deal with losses especially personality change and memory loss. Client won lawsuit. Self-supporting now. Owns own business. Mainly entire family involved in rehab process and client enjoys successful occupation. Has his own Animal Humane Society. Mother employed. Brother finishing college.*

Case #3 *Client who is a 24-year old Indian female who was diagnosed with MS, whose mother gave her encouragement financially and emotionally who became 1994 college graduate in Computer Technology.*

Case #4 *...client's grandfather and grandmother have helped the client. The client has been staying with them off and on in order to work. As of*

right now the client is still working and doing good. The client has grown in self-esteem by the support he has gotten from family.

Negative Family Influence

Twenty-two (22) respondents answered the question asking them to describe a situation where family involvement negatively influenced the client's rehabilitation. Ten (10) of the 22 respondents cited incidents where a family member had contributed to a relapse in drinking and chemical behavior, or at the very least, had made it very difficult for a client who was attempting to maintain sobriety. Three respondents cited cases where the family member undermined the client's self esteem as is reflected in this comment, *"Client wanted to receive further training. Her mother made negative comments . . . degraded and humiliated her . . . wouldn't let . . . client make a copy of previous years tax form so client could apply for financial aid."* Three respondents cited having had no memorable problems with client families.

Rehabilitation System Which Focuses on Family

Out of the six (6) directors who responded to a question regarding a family-focused rehabilitation system, two (2) stated that increasing monetary resources to provide services would be an important facet of designing such a system. In addition to increasing monetary resources, ability to provide transportation, and possibly a facility that would include space to accommodate family members were suggested. One director suggested the creation and staffing of a position for a family counselor/community educator. This same director suggested the creation of a family interview instrument which would help to identify supportive family services. Another director suggested a protocol for identifying clients' needs, how those needs are affected by family dynamics, what resources would support the

family who in turn would support the client toward a successful rehabilitation. All director responses maintained a somewhat varied approach to families, but could be summarized by the statement, *"Invite but do not make mandatory their participation, and if they like, they'll contribute to the rehab plan."*

Eleven (11), or half of the 22 direct service staff respondents to the survey answered this question. Suggestions included more emphasis on outreach to families which would involve counselors making home visits, the involvement of families in the classes available to clients (particularly substance abuse), and possibly requiring a certain number of family members to participate in the rehabilitation process. This required participation would be enhanced by targeted outreach and scheduling meetings at times that worked for family members. It was suggested that families be involved in the rehabilitation process from the beginning and that attention be paid to meeting their needs in order to support that participation. One respondent also suggested that "a full-blown rehabilitation facility" be established in the respondent's community. Still another direct services staff responded, *"I'm happy with our system. We learn sometimes right along with the client. Each situation is different."* Table 16 is a compilation of the needs identified by 18 respondents as regards the resources necessary to implement a family-focused rehabilitation delivery system.

Table 16 Resources Necessary for Family-Focused Rehabilitation System	
Need	**Frequency (N)**
Funding resources (outreach/family support)	9
Additional staff (outreach/drivers)	6
Facilities (new & larger meeting space)	4
Training (family outreach & allowed services)	3
Support services (interview instrument, resource list case monitoring system)	3

Concluding Comments

Fifteen (15) people provided comment when given an open opportunity to say whatever the respondent wished. All 15 respondents affirmed the usefulness and importance of involving the family in the rehabilitation process. Example comments included:

> *...no one is an island. We are all members of a unit whether extended or immediate families--and we need each other to thrive!*

> *The direct VR process for a client is often a family environmental rehabilitation process. Providing services first to the client will only*

treat a symptom of the situation, but will not provide a long-term solution for the problem.

...Encouragement from the family builds the confidence and determination in the one who is seeking the help. If the life-line is not strong, the steps that have to be taken seem hopeless and not worth the effort and work it takes to reach the end result which is why you start this to begin with...

...the family that heals together sure has a heck of a chance to be well together.

Training Needs of Directors and Direct Services Staff

The majority [95% (21)] of direct services staff reported that they would like to receive training "devoted to enhancing family involvement in the client's rehabilitation process;" one direct services staff (5%) reported having received sufficient training in this area. The majority [73% (8)] of directors also reported that they would like to receive such training, while two (18%) directors reported that they were not interested in training to enhance family involvement. The areas of training need identified by direct services staff as being most important are listed in Table 17. The areas of training need identified by directors as being most important are listed in Table 18. The majority of both direct services staff and directors reported that they preferred to receive training in the form of short workshops (1 - 2 days) (see Table 19).

Table 17
Areas of Training Needed by Direct Services Staff

Area of Training	% Identifying as "Most Important"	Rank
Strategies for incorporating the family in rehabilitation	32	1
Identifying services available to families	27	2
Family and group counseling techniques	18	3
Legislation and policy regarding family involvement in VR	14	4
Performing family needs assessments	9	5
Working with the extended family	9	5
Multicultural aspects of family and rehabilitation	5	6

Table 18
Areas of Training Needed by Directors

Area of Training	% Identifying as "Most Important"	Rank
Legislation and policy regarding family involvement in VR	27	1
Family and group counseling techniques	18	2
Strategies for incorporating the family in rehabilitation	18	2
Multicultural aspects of family and rehabilitation	18	2
Performing family needs assessments	9	3
Identifying services available to families	9	3
Working with the extended family	-0-	-0-

Table 19
Preferred Types of Training

Types of Training	% Direct Services Staff	% Directors
Short Workshops	68	73
College Credit Courses	50	27
Extended Seminars	50	27
In-service Training in Agency	27	36

The majority [59% (13)] of direct services staff reported that they would like to receive C.R.C. (certified rehabilitation counselor) credit for training, while 46% (5) of the directors reported that they would like to receive C.R.C. credit. Almost a third [32% (7)] of the direct services staff reported that they would like to receive continuing education credit, compared with 27% (3) of the directors. Additional forms of training information helpful to tribal VR staff are listed in Table 20.

Table 20
Forms of Training Helpful to Tribal VR Staff

Forms of Helpful Training	% Direct Services Staff	% Directors
Newsletters	64	64
Videotapes	64	82
Brochures	50	64
Manuals	46	64
Computer Access to Data Bases	32	18
Audio Tapes	14	27
Electronic Bulletin Boards	9	18
CD-ROM Disks	9	-0-

DISCUSSION

Of the 18 tribal VR directors who agreed to participate in this research, 10 (56%) completed a *director survey* instrument designed to elicit information regarding general information in terms of both program and client characteristics. In addition, 36 Section 130 project staff, including 11 directors, completed a *staff survey* instrument designed to elicit more specific information regarding services and supports provided to families. A total of 15 tribal VR projects are represented in the research results.

Based on information obtained through the *director survey*, the plurality, or most (40%) of the projects were administered through tribal departments of education. Most, or half (50%) of the responding projects served communities of up to 10,000 residents. The majority (80%) reported having up to 5 staff funded through Section 130 dollars, serving an average of 33 clients each. On average, the projects each had served 82 clients in the past year, with the plurality (40%) citing alcohol/substance abuse as the most common disabling condition among their clients. Responding directors reported a wide range of unemployment in the communities they served, from 6% to 90%, with a median unemployment rate of 49%. Employment opportunities were reported to be concentrated in services areas such as health care and tourism.

The majority [90% (9)] of directors *strongly agreed* or *agreed* that they encouraged staff to involve the family in all aspects of the rehabilitation process. Importantly, while only 40% (4) *strongly agreed/agreed* that they had provided opportunities for staff to participate in training related to family issues in the past; 80% (8) *strongly agreed/agreed* that they would support opportunities for staff members to attend any such future training.

Of those persons responding to the *staff survey*, the majority (83%) were American Indian or Alaska Native. Staff were equally divided between males and females, with an average age of 38. The plurality (42%) had held their position less than one year, and had also worked in the rehabilitation profession for less than one year (31%). A large majority (83%) had worked in the rehabilitation profession for five years or less. Of the 11 directors responding to the *staff survey*, the majority (64%) were male; the majority of directors (64%) were also American Indian. The directors were, on average, 41 years of age. Three (27%) of the responding directors were certified

rehabilitation counselors (C.R.C.). Direct services staff (n=22) were equally divided between females and males, were predominately American Indian or Alaska Native (95%), and were an average of 37 years old. None of the responding direct services staff were certified rehabilitation counselors (C.R.C.).

Services to Clients and their Families

On average, direct services staff reported being assigned 36 clients, and reported dealing primarily with persons having, for example, alcohol or substance abuse disorders, learning disabilities, and diabetes. While direct services staff reported counseling and guidance to be the most frequently provided service to their clients (ranked #1 out of 27), family counseling was much less frequently provided (ranked #21 out of 27).

The top three services in which direct services staff reported involving families included: transportation services, home visitation, and information about the disabling condition. Less frequently provided services included: advocacy for family members, family counseling, multiple-family support groups, and respite care services. The plurality of staff who reported working with family members, just over a third of those responding (36%), reported working with a spouse versus other family members.

Statistically significant differences were found between the mean responses of directors and the mean responses of direct services staff in regard to institutional capacity for family involvement. For example, directors agreed more strongly than direct services staff that "family needs and issues are frequently discussed during case staffing sessions," "my schedule allows me to visit families in their homes to assess their needs," and "my schedule allows me to work with families in various aspects of the rehabilitation process." Both direct services staff and directors agreed that it was important

for families to be involved in key VR services such as initial client orientation, assessment of the client's personal situation, and rehabilitation planning (IWRP).

However, the top three barriers to family involvement as identified by direct services staff included: lack of family transportation, lack of family knowledge about the VR process, and lack of time. Responses to open-ended questions supported these data, but suggested that barriers could be overcome with more funding, more education for both family and service providers, more facilities, and more support staff.

Interestingly, direct services staff and directors differed as regards their perceptions of assessments conducted related to family inclusion. For example, statistically significant differences were found in their mean responses to the following: directors reported that the names and roles of key family members who provided assistance were *always* obtained; direct services staff reported this information was obtained less frequently. Similarly, directors reported that the existing systems of formal support, as well as the role of the extended family in the client's life were *always/usually* assessed; again, direct services staff reported that these data were obtained less frequently.

Four Areas of Follow-up Training Highlighted

Participant responses to the survey, as well as interpretation of these responses by the PAC, highlighted four areas of follow-up information/training needed: (1) knowledge of specific services that can be purchased with VR funds and provided to the family members; (2) examples of what services other Section 130 Projects provide to the families of rehabilitation consumers, and how those services are planned and orchestrated to have positive outcomes for the consumer; (3) training in how

to work productively with families to create a support for the rehabilitation consumer--including how to deal with negative influences from family members that may potentially have a "sabotaging" effect on the rehabilitation service delivery and potential consumer outcomes; and (4) resources to facilitate the education of families as regards assisting their family member in using rehabilitation services effectively.

Honoring Dissemination and Follow-up Requests

As the PAC members and the researchers discussed preliminary responses to the survey, the need to honor the promise to participants to develop a way to address both the prompt dissemination of findings and expressed training needs in some "user friendly" fashion was considered. Participants who responded to the survey were asked to answer questions in relation to the mode of training that best met their individual needs. A continued interest in receiving training in a nationally organized and presented workshop format, particularly when this activity could be combined with other gatherings for which Section 130 providers might already be assembled, was endorsed by providers. This was not an unexpected response.

However, in edition to the call for traditional workshop-type training, PAC members expressed the need for training specific to: (a) individual information needs, (b) specific project location, (c) status of project development, and (d) particulars related to the characteristics of the American Indian populations served. PAC members also stated an interest in training materials that could be incorporated in segments into individual staff meetings and local gatherings as time and subject might dictate.

CONCLUSIONS and RECOMMENDATIONS

It is hoped that the results of this study will give tribal vocational rehabilitation programs a better understanding of the extent to which they are utilizing families to achieve rehabilitation goals. Through the documentation of services being provided to families, and through the identification of barriers which may exist to prevent utilization of families as resources, tribal vocational rehabilitation staff will be in a better position to serve American Indians with disabilities. It is further hoped that these findings will serve rehabilitation counselors who work with American Indians in off-reservation settings in terms of providing a culturally-sensitive family rehabilitation model of rehabilitation service delivery. To that end, the following key findings from this research are summarized below:

1) The term "family," when defined by staff and directors in Section 130 projects, means an extended family. Additionally, that extended family *may* include people who are not related by blood, but have developed a relationship over time, or through meeting mutual needs. Almost half of the respondents indicated that when families had been a problem, it was most often in relationship to alcohol or substance abuse which either enabled the client to use, or made his/her attempt at sobriety and non-usage that much more difficult.

2) While directors endorsed the provision of a broad variety of services to families in support of the rehabilitation of a client, not all directors or direct services staff appeared to have a clear understanding of what is allowed as an approved expenditure or service. That is, although almost all respondents surveyed agreed that the involvement of the family was important to achieving successful rehabilitation closures, there was apparent confusion in relation to what services could be provided to families.

3) While family involvement was seen as important at all stages in the rehabilitation process, barriers to family involvement included: lack of transportation, lack of interest of families in participation in the rehabilitation process, exhibition of dysfunctional behaviors by the family which jeopardize rehabilitation success for the client, and/or the lack of counselor time available to pursue family involvement.

4) Suggestions for overcoming barriers to family involvement in the rehabilitation process focused on education for both rehabilitation staff and family members. Respondents suggested training: (a) for families in order to create greater understanding of the requirements and expectations of the rehabilitation process, (b) for informing families of services that might be provided to the family to support the rehabilitation of the family member/rehabilitation client, and (c) for informing staff as to the resources that a counselor can provide to family members.

5) Both directors and direct service staff suggested greater outreach to families, and the resources to support that outreach, as ways to reach and involve more families in the rehabilitation process. Outreach would include a specific focus of making families more aware of the vocational rehabilitation process.

6) Increased funding to support outreach and family needs was cited as the *largest need to implement a new system that focused on family* members as well as the individual being rehabilitated. Also identified was the need for more staff to provide supportive services such as transportation, as well as facilities with greater space for meetings with families and for training sessions for both families and rehabilitation staff.

A Family-Focused Rehabilitation Intervention Model

Researchers and community rehabilitation advocates have long called for family involvement in rehabilitation to be both positively acknowledged and strengthened. For example, according to Arnold and Case (1993), "despite the value and cost-effectiveness of the natural support system of the family, federal and state policies and practices continue to discriminate in services and funding available to provide in-home care for family members who are . . . disabled" (p. 55)." Noted rehabilitation educator and researcher Dr. Don Linkowski (undated) noted that, "family systems need to be studied in order to understand how they can be best augmented and complemented. . . . In the United States, we have barely scratched the surface in our understanding of how the rehabilitation system and independent living system can effectively interface with family systems. Together these can have powerful effects" (p. 23). Finally, in describing community-based rehabilitation, professionals supported by the World Health Organization have concluded:

> The family of the disabled person is the most important resource. Its skills and knowledge should be promoted by adequate training and supervision, using a technology closely related to local experience. The community should support the basic necessities of life and help the families who carry out rehabilitation at home. . . . Disabled community members and their families should be involved in all discussions and decisions regarding services and opportunities provided for them (Helander, 1993, p. 8).

Participants in the research effort described in this report agree that families should be involved in their clients' rehabilitation, yet they are

functioning in a service delivery model developed from a dominant society values base which focuses on the individual--not on the family. A new service delivery model is needed which acknowledges the role of the family and rewards direct services staff for including the family. Recommendations for such a model are delineated in Table 21.

Table 21
Components of a Family-Focused Rehabilitation Model

- Family-focused model of intervention would be free-flowing, that is, sometimes there may be a service opportunity where the client may be involved and also the family. At other times, the family may be the focus of intervention. Services are not solely provided to either client of family members without possible participation of the other party.
- Home visits would be an integral part of the model in order to ensure active participation in key VR service delivery components such as the IWRP.
- Model would encourage family participation informally as well as formally, through, e.g., participation in potlucks, celebrations, etc.
- Model would have full-time family advocate who could also engage in community education regarding disability and disability prevention.
- Providing family transportation would be seen as key to family involvement.
- Services would be provided in an atmosphere of respect for the family and for the values associated with a collective society.
- Services to the families would be provided and documented without seeing the family as necessarily pathological or as a "client."
- Family orientation to VR services would be an on-going activity.
- Orientation to families would be a part of on-going training for VR staff. Topics to be covered might include, for example, *Introduction to Working with the Family, Family Perspectives of the Rehabilitation Process*, and *Utilizing the Family in Job Development and Job Placement*. CRC credits would be awarded for all training.

Recommendations for Future Research

According to Kelley and Lambert (1992), "systematic studies of the efficacy of family-centered versus client-centered rehabilitation have not been conducted. Nevertheless, the reported clinical experiences indicate potential advantages to integrating family-centered services within a client's rehabilitation program . . . ." (p. 115). This study is considered a progression in a program of family research conducted through the AIRRTC, beginning with a study which indicated a void of VR services being offered to families on two reservations (Marshall, & Cerveny, 1994).

This research has indicated strong administrative and direct services support for providing services to family members. However, services to families are not systematically provided and the actual provision of service appears to be less than the strength of conviction that the services should be provided. Given the limited fiscal resources of tribal VR projects for increased service delivery and limited staff capacity for ongoing participation in research, future research should involve a purposeful sampling of tribal VR clients whose cases have been closed successfully in order to determine what factors associated with family utilization and/or family support may have contributed to their successful vocational rehabilitation outcomes. In this way, VR programs will have a better understanding of what specific family assessments and family interventions are necessary for optimizing the client's vocational rehabilitation.

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APPENDIX A

Survey of Tribal Vocational Rehabilitation Project Directors

Survey of Tribal Vocational Rehabilitation Project Directors

The Utilization of the Family as a Resource
in American Indian Vocational Rehabilitation Projects
(Section 130 Projects)

American Indian Rehabilitation Research and Training Center

Institute for Human Development
Arizona University Affiliated Program
Northern Arizona University
PO Box 5630
Flagstaff, Arizona 86011-5630

Survey Of Tribal Vocational Rehabilitation Project Directors

I. PROGRAM CHARACTERISTICS

PC1. Name of Facility_____

PC2. Operation of Program

Is your program operated by

1. ❒ Tribe
2. ❒ College
3. ❒ Other _____

PC3. Size of Local Community

1. ❒ 500 or less residents
2. ❒ 501 - 1,000 residents
3. ❒ 1,001 - 5,000 residents
4. ❒ 5,001 - 10,000 residents
5. ❒ 10,001 - 25,000 residents
6. ❒ More than 25,000 residents

PC4. Years of Program Operation

How many years has your VR program been operating? _____

PC5. Number of Staff

A. How many staff members work in your project who are funded through Section 130 dollars?

1. ❒ 1-5 employees
2. ❒ 6-10 employees
3. ❒ 11-20 employees
4. ❒ More than 20 employees

B. How many staff members work in your project who are funded through other sources?

1. ❒ 1-5 employees
2. ❒ 6-10 employees
3. ❒ 11-20 employees
4. ❒ More than 20 employees

PC6. Caseload

What is the average number of clients assigned to each of your counseling staff? _____

PC7. Is your program funded through:

1. ❒ Section 130 monies ____ %
2. ❒ Tribal monies ____ %
3. ❒ Other _____ ____ %

PC8. Under what administrative unit is your project based?

1. ❒ Health
2. ❒ Education
3. ❒ Social services
4. ❒ Other _____

PC9. What equipment for delivery of training does your facility currently have access to? (Please check all that apply.)

1. ❒ VCR Equipment
2. ❒ PC Computer Model: _____
3. ❒ Macintosh Computer Model: _____
4. ❒ Slide Projector
5. ❒ Overhead Projector
6. ❒ CD Rom Drive
7. ❒ Computerized Projection System
8. ❒ Other _____

II. CLIENT CHARACTERISTICS

CC1. Number of Clients

What is the total number of clients your agency has worked with in the past year (all disabilities)? _____

CC2. Client Ethnicity

What percentage of clients are American Indian or Alaska Native? _____ %

CC3. Client Tribal Affiliation

A. Primary tribal affiliation of clients _____ %_____

B. Next common client tribal affiliation _____ %_____

CC4. Gender of Clients (number)

1. ___ Male clients 2. ___ Female clients

CC5. Primary Disability Types

What are the ***three*** primary disabling conditions among clients who receive services at your center? (Please identify three only, with "1" being the most common disability, "2" being the 2nd most common disability, and "3" being the 3rd most common disability.)

_____ 1. Speech Impairments
_____ 2. Hearing Impairments
_____ 3. Visual Impairments
_____ 4. Orthopedic Impairments (i.e., missing extremities)
_____ 5. Paralysis (partial or complete)
_____ 6. Heart Disease
_____ 7. Cancer

(Question continues on next page)

_____ 8. Mental Retardation
_____ 9. Learning Disability
_____ 10. Alcoholism/Substance Abuse
_____ 11. AIDS/HIV
_____ 12. Diabetes
_____ 13. Tuberculosis
_____ 14. Arthritis
_____ 15. Development Disabilities (not including mental retardation)
_____ 16. Severe and Persistent Mental Illness
_____ 17. Other Emotional Disability
_____ 18. Other _____

CC6. Distance from VR Service Center

On average, how many miles do your clients travel to reach your center?

1. ❒ 0-5
2. ❒ 6-10
3. ❒ 11-20
4. ❒ 21-50
5. ❒ over 50

CC7. Approximately what percentage of clients live alone? _____ %

III. LABOR MARKET RESOURCES

LM1. Unemployment Rate

What is the unemployment rate in your local area? _____ %

LM2. Employment Opportunities

What percentage of the following employment opportunities are available in your local area: (Be as accurate as possible. If you are not sure, please leave the space blank.)

_____ % 1. Professional
_____ % 2. Clinical
_____ % 3. Sales
_____ % 4. Service: tourism
_____ % 5. Service: human services
_____ % 6. Service: health care
_____ % 7. Service: education
_____ % 8. Agriculture
_____ % 9. Industrial
_____ % 10. Self-employment
_____ % 11. Other _____
_____ % 12. Other _____

LM3. **What percentage of your closures in the *past year* were:** (Be as accurate as possible. If you are not sure, please leave the space blank.)

_____ % 1. Competitive employment - Professional
_____ % 2. Competitive employment - Clerical
_____ % 3. Competitive employment - Sales
_____ % 4. Competitive employment - Service
_____ % 5. Competitive employment - Agricultural
_____ % 6. Competitive employment - Industrial
_____ % 7. Sheltered Workshop
_____ % 8. Self-employment
_____ % 9. State Agency Managed Business Enterprise Program
_____ % 10. Homemaker
_____ % 11. Unpaid Family Worker
_____ % 12. Student/Trainee
_____ % 13. Other _____
_____ % 14. Other _____

IV. ADDITIONAL QUESTIONS

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
AQ1. I have provided opportunities for staff to participate in training related to family involvement issues.	1	2	3	4	5
AQ2. I support opportunities for staff members interested in family issues to attend any future training.	1	2	3	4	5
AQ3. I encourage staff to involve the family in all aspects of the rehabilitation process.	1	2	3	4	5
AQ4. Our facility is well designed to support interaction with the families of our consumers.	1	2	3	4	5

Thank you! Now, please complete the
Survey of Tribal VR Project Staff

APPENDIX B

Survey of Tribal Vocational Rehabilitation Staff

Survey of Tribal Vocational Rehabilitation Staff

The Utilization of the Family as a Resource
in American Indian Vocational Rehabilitation Projects
(Section 130 Projects)

American Indian Rehabilitation Research and Training Center

Institute for Human Development
Arizona University Affiliated Program
Northern Arizona University
PO Box 5630
Flagstaff, Arizona 86011-5630

SURVEY OF TRIBAL VOCATIONAL REHABILITATION STAFF

I. DEMOGRAPHIC INFORMATION

DI1. ID # _____
(Computer Use Only)

DI2. Sex 1. ❒ Male 2. ❒ Female

DI3. Age (in years) _____

DI4. Ethnicity

1. ❒ American Indian **tribal affiliation(s)** _____
2. ❒ Alaska Native **tribal affiliation(s)** _____
3. ❒ Asian or Pacific Islander
4. ❒ African-American, not of Hispanic Origin
5. ❒ Hispanic
6. ❒ Caucasian, not of Hispanic Origin

DI5. Education Level

Please indicate your highest level of education and your areas of emphasis:

1. ❒ Less than High School Diploma
2. ❒ High School Diploma
3. ❒ GED or High School Equivalency
4. ❒ Some College, but not Associate's Degree
5. ❒ Associate's Degree _____ (area of emphasis)
6. ❒ More than Associate's Degree, but not Bachelor's Degree
7. ❒ Bachelor's Degree _____ (area of emphasis)
8. ❒ Some Graduate Work, but not Master's Degree
9. ❒ Master's Degree _____ (area of emphasis)
10. ❒ More than a Master's Degree, but not Doctoral Degree
11. ❒ Doctoral Degree _____ (area of emphasis)
12. ❒ Professional Degree (e.g., M.D., D.M.D. or J.D.)
13. ❒ Other _____ (Explain) _____

DI6. Certification

What additional certification have you received that is related to your job?
(Select all that apply.)

1. ❒ Certified Rehabilitation Counselor (CRC)
2. ❒ Licensed Professional Counselor
3. ❒ Certified Professional Counselor
4. ❒ Marital And Family Counseling
5. ❒ Chemical Dependency Counseling
6. ❒ Other _____ (Explain) _____

DI7. **Other areas of additional training and expertise** _____

II. EMPLOYMENT INFORMATION

EI1. **Name of vocational rehabilitation facility:** _____

EI2. **Is your employment with the tribal VR project:**

1. ❒ Full-time (40 hours per week)
2. ❒ Part-time (1-10 hours per week)
3. ❒ Part-time (11-20 hours per week)
4. ❒ Part-time (21-30 hours per week)
5. ❒ Part-time (31-39 hours per week)

EI3. **What is your position title?** _____

EI4. **Is your position funded by Section 130 dollars?**

1. ❒ Yes 2. ❒ No 3. ❒ I don't know

If "No", what is the source of funding for your position? _____

EI5. **Years in Position**

How many years have you held this position?

1. ❒ Less than 1 year
2. ❒ 1-2 years
3. ❒ 3-5 years
4. ❒ 6-10 years
5. ❒ 11-15 years
6. ❒ 16-20 years
7. ❒ More than 20 years

EI6. **Years in Rehabilitation Field**

How many years have you worked in the rehabilitation profession?

1. ❒ Less than 1 year
2. ❒ 1-2 years
3. ❒ 3-5 years
4. ❒ 6-10 years
5. ❒ 11-15 years
6. ❒ 16-20 years
7. ❒ More than 20 years

EI7. Work Responsibilities

For the next three questions, please respond in the box below:

A. In general, what are your top 3 work responsibilities? (for example, counseling, case management, supervision)

B. How many hours per week do you *typically* devote to each activity?

	A. Activity	B. Hrs. /Wk.
1.		
2.		
3.		

EI8. Do you supervise other staff?

1. ❒ Yes 2. ❒ No If "Yes", how many? _____

EI9. How many clients are assigned to you to work with? _____

EI10. What are the *three* primary disabling conditions among the clients with whom you work? Please identify only three, with "1" being the most common disability, "2" being the 2nd most common disability, and "3" being the 3rd most common disability.

_____ 1. Speech Impairments
_____ 2. Hearing Impairments
_____ 3. Visual Impairments
_____ 4. Orthopedic Impairments (i.e., missing extremities)
_____ 5. Paralysis (partial or complete)
_____ 6. Heart Disease
_____ 7. Cancer
_____ 8. Mental Retardation
_____ 9. Learning Disability
_____ 10. Alcoholism/Substance Abuse
_____ 11. AIDS/HIV
_____ 12. Diabetes
_____ 13. Tuberculosis
_____ 14. Arthritis
_____ 15. Development Disabilities (not including mental retardation)
_____ 16. Severe and Persistent Mental Illness
_____ 17. Other Emotional Disability
_____ 18. Other _____

III. SERVICES PROVIDED TO INDIVIDUAL CLIENTS

SE1. I provide the following services to my individual clients (Circle one response per item):

	Service	Always	Usually	Sometimes	Rarely	Never
A.	Eligibility Assessment/Intake	1	2	3	4	5
B.	Assessment of Disability Status	1	2	3	4	5
C.	Assessment of Personal Situation	1	2	3	4	5
D.	Vocational Assessment	1	2	3	4	5
E.	Rehabilitation Planning (IWRP)	1	2	3	4	5
F.	Job Placement and Referral	1	2	3	4	5
G.	Educational Training	1	2	3	4	5
H.	Business/Vocational Training	1	2	3	4	5
I.	On-the-Job Training	1	2	3	4	5
J.	Activities of Daily Living Training	1	2	3	4	5
K.	Assistive Technology	1	2	3	4	5
L.	Counseling and Guidance	1	2	3	4	5
M.	Work-site Visitation	1	2	3	4	5
N.	Transportation	1	2	3	4	5
O.	Independent Living	1	2	3	4	5
P.	Home Visitation	1	2	3	4	5
Q.	Family Counseling	1	2	3	4	5
R.	Case Management and Referral	1	2	3	4	5
S.	Utilizing Informal Support Networks	1	2	3	4	5
T.	Group Therapy	1	2	3	4	5
U.	Native Healing or Counseling	1	2	3	4	5
V.	Physical Restoration	1	2	3	4	5
W.	Supported Employment	1	2	3	4	5
X.	Post-employment Services	1	2	3	4	5
Y.	Rehabilitation Orientation	1	2	3	4	5
Z.	Financial Planning	1	2	3	4	5
AA.	Financial Assistance	1	2	3	4	5
BB.	Interpretation (Native Language, ASL)	1	2	3	4	5
CC.	Child Care	1	2	3	4	5
DD.	Advocacy	1	2	3	4	5
EE.	Modification of Housing to Facilitate Access	1	2	3	4	5
FF.	Other _____	1	2	3	4	5

IV. SERVICES PROVIDED TO FAMILY MEMBERS

SP1. In the last 12 months, I have involved families of rehabilitation clients in the following activities (Circle one response per item):

Service	Always	Usually	Sometimes	Rarely	Never
A. Rehabilitation Orientation	1	2	3	4	5
B. Client Eligibility Assessment Intake	1	2	3	4	5
C. Participation in Diagnosis and Evaluation	1	2	3	4	5
D. Assessment of Family Expectations for Rehabilitation	1	2	3	4	5
E. Involvement in Training Planning	1	2	3	4	5
F. Sharing Information about Disabling Condition and Health Effects	1	2	3	4	5
G. Participation in IWRP Planning	1	2	3	4	5
H. Family Counseling and Progress Reviews	1	2	3	4	5
I. Assessment of Family Needs	1	2	3	4	5
J. Family Case Management & Referral	1	2	3	4	5
K. Involvement in Job Placement	1	2	3	4	5
L. Financial Planning	1	2	3	4	5
M. Financial Assistance to Families	1	2	3	4	5
N. Interpretation (Native Language, ASL)	1	2	3	4	5
O. Transportation Services	1	2	3	4	5
P. Child Care Services	1	2	3	4	5
Q. Home Visitation	1	2	3	4	5
R. Respite Care Services	1	2	3	4	5
S. Advocacy for Family Members	1	2	3	4	5
T. Planning for Independent Living	1	2	3	4	5
U. Planning for Future Care/Support of Consumer	1	2	3	4	5
V. Skill Training in Personal Assistance/ Supportive Activites	1	2	3	4	5
W. Integration of Assistive Technology Devices	1	2	3	4	5

(Question continues on next page)

Service	Always	Usually	Sometimes	Rarely	Never
X. Multiple Family Support Group	1	2	3	4	5
Y. Involvement in Post-employment Services	1	2	3	4	5
Z. Modification of Housing to Facilitate Access	1	2	3	4	5
AA. Utilizing Informal Support Networks	1	2	3	4	5
BB. Native Healing or Counseling	1	2	3	4	5
CC.. Other _____	1	2	3	4	5

V. BARRIERS TO FAMILY INVOLVEMENT

BF1. I have experienced the following as barriers to effective involvement of family members in the rehabilitation process (Circle one response per item):

Barrier	Always	Usually	Sometimes	Rarely	Never
A. Lack of Family Transportation	1	2	3	4	5
B. Lack of Time/Scheduling	1	2	3	4	5
C. Inadequate Space for Family Meetings	1	2	3	4	5
D. Lack of Counselor Awareness of Relevant Policies	1	2	3	4	5
E. Lack of Client Awareness of Relevant Policies	1	2	3	4	5
F. Lack of Family Knowledge about VR Process	1	2	3	4	5
G. Budget Limitations	1	2	3	4	5
H. Resistance from Family Members	1	2	3	4	5
I. Lack of Agency Policy or Procedure	1	2	3	4	5
J. Lack of Counselor Incentive	1	2	3	4	5
K. Lack of Child Care	1	2	3	4	5
L. Language Differences	1	2	3	4	5
M. Inability of Counselor to Make Home Visits	1	2	3	4	5
N. Counselor Hesitant to Make Home Visits	1	2	3	4	5

(Question continues on next page)

Barrier	Always	Usually	Sometimes	Rarely	Never
O. Lack of Reward to Counselor	1	2	3	4	5
P. Size of Caseload	1	2	3	4	5
Q. Lack of Support from Supervisor	1	2	3	4	5
R. Lack of Building Accessibility	1	2	3	4	5
S. Lack of Family Expectation That They Should Be Involved	1	2	3	4	5
T. Lack of Counselor Expectation That Family Would Be Involved	1	2	3	4	5
U. Other _____	1	2	3	4	5

VI. STRUCTURE AND PROCESS OF FAMILY INVOLVEMENT

The following statements deal with broader systemic questions about institutional support for family participation. (Circle one response per item.)

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
SP1.	Our facility is adequate in size and space to regularly accommodate family members in the rehabilitation process.	1	2	3	4	5
SP2.	I am satisfied with our agency's activities in regard to encouraging family involvement.	1	2	3	4	5
SP3.	My schedule allows me to work with families in various aspects of the rehabilitation process.	1	2	3	4	5
SP4.	My schedule allows me to visit families in their homes to assess their needs.	1	2	3	4	5
SP5.	Our center has the capacity to transport family members from their homes so that they may be included in the rehabilitation process.	1	2	3	4	5

(Question continues on next page)

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
SP6.	My agency has outlined policy and procedures for encouraging greater family participation.	1	2	3	4	5
SP7.	My agency offers orientation sessions to family members, consumers, and others about the range of rehabilitation services.	1	2	3	4	5
SP8.	Family needs and issues are frequently discussed during case staffing sessions.	1	2	3	4	5
SP9.	It is possible to record when services to families have been provided using my agency's status code system.	1	2	3	4	5

VII. ATTITUDES TOWARDS FAMILY INVOLVEMENT

For the following statements, circle the resource that most accurately represents your perceptions and beliefs about family involvement.

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
PA1.	Participation of the consumer's family in various aspects of the rehabilitation process can improve the client's opportunities for successful vocational outcome.	1	2	3	4	5
PA2.	I believe in the importance of taking steps to involve the family to the fullest extent in the clients' rehabilitation program.	1	2	3	4	5
PA3.	My supervisor encourages me to involve families in rehabilitation process.	1	2	3	4	5
PA4.	My co-workers express positive support for including families in the rehabilitation process.	1	2	3	4	5
PA5.	Participation of the consumer's family in various aspects of the rehabilitation process can hinder the client's opportunities for successful vocational outcome.	1	2	3	4	5

(Question continues on next page)

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
PA6.	Consumers request that their family members be present in one or more aspects of the rehabilitation process.	1	2	3	4	5
PA7.	Consumers are generally supportive of any efforts to include key members of their family in their vocational rehabilitation program.	1	2	3	4	5
PA8.	Family members are not typically interested in participating in their relative's VR program.	1	2	3	4	5
PA9.	Extended family members should be invited to participate in the rehabilitation program of clients.	1	2	3	4	5

VIII. IMPORTANCE OF FAMILY INVOLVEMENT

IF1. Assess the importance of the family member's participation in each of the activities listed below.

	Not Important				Very Important
A. Initial Client Orientation	1	2	3	4	5
B. Eligibility Assessment	1	2	3	4	5
C. Assessment of Personal Situation	1	2	3	4	5
D. Vocational Assessment	1	2	3	4	5
E. Rehabilitation Planning (IWRP)	1	2	3	4	5
F. Placement	1	2	3	4	5
G. Follow-up	1	2	3	4	5

IF2. On a scale of 1-10, with 10 being the best, how would you rate your agency's commitment to family participation in comparison to other priorities? _____

IF3. When working with clients, I regularly seek to evaluate or identify:

Activity	Always	Usually	Sometimes	Rarely	Never
A. Amount of Family Involvement Desired by Client	1	2	3	4	5
B. Family Expectations of the Rehabilitation Process	1	2	3	4	5
C. Name and Roles of Key Family Members Who Provide Assistance	1	2	3	4	5
E. Role of the Extended Family in Client's Life	1	2	3	4	5
F. Existing Systems of Formal Support	1	2	3	4	5
G. Existing Systems of Informal Support	1	2	3	4	5
H. Needs of Family Members	1	2	3	4	5
I. Potential Barriers to Family Participation	1	2	3	4	5
J. Family History	1	2	3	4	5

IF4. I typically assess the ways that various family members assist my client with:

A. Transportation 1. ❒ Yes 2. ❒ No
B. Interpretation (Native Language, ASL) 1. ❒ Yes 2. ❒ No
C. Bathing and Personal Assistance 1. ❒ Yes 2. ❒ No
D. Shopping/Home Maintenance 1. ❒ Yes 2. ❒ No
E. Mobility Assistance 1. ❒ Yes 2. ❒ No
F. Developing Job Skills 1. ❒ Yes 2. ❒ No
G. Developing Educational Skills 1. ❒ Yes 2. ❒ No
H. Developing Social Skills 1. ❒ Yes 2. ❒ No
I. Other _____ 1. ❒ Yes 2. ❒ No

IF5. In the last 12 months, I have provided services to the following family members:

Family Member	Types of Services
A. Spouses	
B. Brothers	
C. Sisters	
D. Mothers	
E. Fathers	
F. Mothers-in-law	
G. Fathers-in-law	
H. Grandmothers	
I. Grandfathers	
J. Daughters	
K. Sons	
L. Grandchildren	
M. Cousins	
N. Nephews/Nieces	
O. Aunts	
P. Uncles	
Q. Boy/Girlfriends	
R. Friends	
S. Other	

IX. TRAINING NEEDS FOR PROVIDING FAMILY SERVICES

TN1. Have you attended any training sessions devoted to enhancing family involvement in the client's rehabilitation process?

1. ❒ Yes, I have received sufficient training in this area.
2. ❒ Yes, but I desire more training in this area.
3. ❒ No, but I would like to receive training.
4. ❒ No, I am not interested in this kind of training.

[If you selected 2 or 3, please proceed to TN2. If you selected 1 or 4, please proceed to page 13.]

TN2. If you would like additional training, what areas would you be most interested in? (Please identify 3 training needs, with "1" being most important, "2" being 2nd most important, and "3" being 3rd most important.)

_____ 1. Legislation and policy regarding family involvement in VR
_____ 2. Strategies for incorporating the family in rehabilitation
_____ 3. Family and group counseling techniques
_____ 4. Performing family needs assessments
_____ 5. Identifying services available to families
_____ 6. Working with the extended family
_____ 7. Multicultural aspects of family and rehabilitation
_____ 8. Other _____
_____ 9. Other _____
_____ 10. Other _____

TN3. What types of training would you prefer to attend? (Please check all that apply.)

1. ❒ College Credit Courses (graduate or undergraduate)
2. ❒ Extended Seminars (3-7 days)
3. ❒ Short Workshops (1-2 days)
4. ❒ Inservice training in your agency
5. ❒ Other _____

TN4. What other forms of training information would be helpful? (Please check all that apply.)

1. ❒ Brochures
2. ❒ Newsletters
3. ❒ Manuals
4. ❒ Electronic Bulletin Boards
5. ❒ Computer Access to Data Bases
6. ❒ Audiotapes
7. ❒ Videotapes
8. ❒ CD Rom Disks
9. ❒ Other _____

TN5. Would you like to receive:

1. ❒ CRC credit
2. ❒ CE credit
3. ❒ Other

X. OPEN RESPONSE QUESTIONS

OR1. How would you define the term 'family' with respect to American Indian/Alaska Native clients?

OR2. What is your understanding of the tribal vocational rehabilitation services that can be provided to the family members of your clients?

OR3. How would you like to see the family involved in the rehabilitation process?

OR4. What are five barriers you have experienced to providing adequate services to families?

1.

2.

3.

4.

5.

OR5. What suggestions do you have for overcoming these barriers?

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

OR6. Please provide a case example from your experience where a client's family has made a significant positive contribution to the client's successful rehabilitation.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

OR7. How would you design a rehabilitation system which focused on the needs of the family in addition to the needs of the individual?

_____

_____

_____

_____

_____

_____

_____

OR8. What would you need to implement this system (e.g., physical structure, case management, budget)?

OR9. Please describe a situation from your experience where family involvement has negatively influenced the client's rehabilitation.

OR10. What other comments would you like to make about the involvement of family in the rehabilitation process?